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Select Committee on Drugs

HEARINGS

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Wednesday,
the 26th of October, 1960,
at 10.30 a.m.

COMMITTEE:

MR. H. L. ROWNTREE, Q.C. Chairman

MR. A. WREN

MR. J. A. FULLERTON

MR. J. TROTTER

MR. R. E. SUTTON

MR. R. J. BOYER

MR. N. WHITNEY

MR. H. J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G. F. LAVERGNE

MR. S. J. GADSBY, F.C.I.S., Secretary

MR. HAROLD A. RICE, Committee Counsel

MR. W. J. AYERS Accounting
Consultant to the
Committee



1
2 --- Hearing resumed at 10.30 a.m.

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4 THE CHAIRMAN: Gentlemen, we will resume
5 this morning, and Mr. Rice, where did we leave off?

6 MR. RICE: Mr. Chairman, Mr. Conder had
7 completed answering my questions that I had to present
8 to Mr. Conder yesterday. I understand some of the
9 Committee may have some questions they wish to ask Mr.
10 Conder.

11 THE CHAIRMAN: Yes. Now, Mr. Trotter,
12 when we adjourned yesterday afternoon you were asking
13 some questions. Have you any other questions?

14 MR. TROTTER: No, I have no further
15 questions.

16 THE CHAIRMAN: Shall we then go around
17 the table? Mr. Sutton?

18 MR. SUTTON: No.

19 THE CHAIRMAN: Mr. Price?

20 MR. PRICE: Could you tell us how your
21 Association is financed?

22 MR. CONDER: Yes. It is financed by
23 dues which are paid by the member companies according
24 to classifications of sales.

25 MR. PRICE: I see. Would it be a fair
26 question to ask you your schedule of fees?

27 MR. CONDER: I can supply you with a
28 copy of them. I don't have one with me. It varies
29 through 14 different classifications.

30 MR. PRICE: Can you tell us the approximate



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income of the Association in 1960?

MR. CONDER: From membership dues in the Association, it would run in the neighbourhood of \$60,000.

MR. PRICE: Could you tell us if the Association does any advertising on behalf of members to acquaint the public of the advantages of buying your members' drugs?

MR. CONDER: No. Generally it doesn't. We ran one advertisement. It is the first time to my knowledge we have ever done anything of this type, in an issue of the Financial Post based on health. We published a small booklet which was just limited distribution. It was not for general distribution to the public as such.

MR. PRICE: Could you tell us if any of your members maintain research or manufacturing facilities in Mexico?

MR. CONDER: To the best of my knowledge none of our Canadian companies do, although some of the subsidiaries of Canadian companies may conceivably be connected with interests which do have companies in Mexico.

MR. PRICE: That is all I have, Mr. Chairman.

THE CHAIRMAN: Mr. Bryden?

MR. BRYDEN: Mr. Conder, I would like to first of all ask you questions on your quite detailed section on quality control. As I understand both from



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2 Doctor Morrell and the essence of what you say here,
3 the guarantee of quality is essentially the manufacturer's
4 name on the label of a product. Would that be so?

5 MR. CONDER: It would depend on the
6 company as it stands.

7 MR. BRYDEN: I mean your indication of
8 quality rather than guarantee?

9 MR. CONDER: Yes, that is correct.

10 MR. BRYDEN: That would be the way a
11 person, at least a doctor, shall we say, that would be
12 the only way he would be able to find out? He couldn't
13 test the stuff himself?

14 MR. CONDER: Yes.

15 THE CHAIRMAN: Well, that is a question
16 of reliance, isn't it? A reliance on the product that
17 anyone sells, whether it is an automobile or anything
18 else.

19 MR. BRYDEN: There are somewhat more
20 urgent factors involved here since it is a matter of
21 health, and I believe it might be a matter of life or
22 death in some instances.

23 THE CHAIRMAN: Just so that I will follow
24 you, Mr. Bryden, this distinguishes between the companies
25 that are able to establish, shall we say, reputability,
26 as against those who cannot, isn't that the point?

27 MR. BRYDEN: Yes. I am also trying
28 to get exactly what is the test of reliability or
29 reputability, which I take it is the manufacturer's
30 name.



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2 If there was a manufacturer who was known
3 to have quality control procedures, his name on the
4 label would be an indication that the product could be
5 relied upon and would be as stated.

6 MR. CONDER: It would be from the
7 doctor's viewpoint, through experience over the years.

8 MR. BRYDEN: He has nothing else to go
9 on except experience over the years?

10 MR. CONDER: The doctor?

11 MR. BRYDEN: Yes.

12 MR. CONDER: That is correct.

13 MR. BRYDEN: So that he could hardly
14 have had experience with all of them?

15 MR. CONDER: No, that is true.

16 THE CHAIRMAN: I don't want to, and it
17 is not my intention or desire to ever interfere with
18 questioning of any member of this Committee and I
19 state that at the moment. But how in the world else
20 could a fellow -- what happens to the doctor who
21 graduates and has a patient five minutes after he has
22 got the degree? What does he do?

23 MR. BRYDEN: I think that is a very
24 important problem and I would like to get into it if
25 you will permit me. It is a major problem in
26 government institutions ----

27 THE CHAIRMAN: It is a major problem for
28 either a politician who has just been elected or a
29 lawyer who has just been called to the Bar. What is
30 the difference?



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MR. BRYDEN: What is the difference in what? I don't know what a politician who has just been elected has to do with it.

THE CHAIRMAN: He probably says a lot of things he shouldn't say.

MR. BRYDEN: That may be, but again that does not affect the health of the nation. You can get as personal as you like, or as impersonal, I don't care, but I want to ask questions, and I would ask if I have the right to ask them.

THE CHAIRMAN: Yes, but we have a duty to the Committee and we have a duty to ourselves. I would like to be able to follow your line of reasoning. What are you attempting to prove? That the doctors have no right to prescribe if they have no experience?

MR. BRYDEN: No, I am not attempting to prove anything, but I am trying to get into a problem which is a difficult one as I see it, and I would like to see if there are any lines of solution, and to begin with I just want to be sure that I know exactly what the situation is, that it is the manufacturer's name ---

THE CHAIRMAN: Just a minute. Your premise is we are approaching the problem as laymen?

MR. BRYDEN: That is correct.

MR. HUME: So that I may understand the question, as counsel, what you are saying in another way is a good name is a valuable asset. Isn't that what you are saying?



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MR. BRYDEN: At the moment, I am just asking the question, and I want to know what it is that is the guarantee, and I take it, it is the manufacturer's name on the label which is required to be there by law, but the brand name on the other side of the coin would not be in itself any guarantee of quality?

MR. CONDER: The guarantee of quality, Mr. Bryden, is the work which is conducted in the manufacturing establishment during the production of the particular drug in question.

MR. BRYDEN: So that if that company has good practices, then its name would be an indication of the drugs that are made under good practices?

MR. CONDER: If a company has developed for itself over the years a reliability for producing a product which meets the qualifications and requirements of the medical profession or the institutional purchasers, then that comes back into the form of reliability on the company's name, which actually is backed by the facilities which that company maintains.

MR. BRYDEN: And this must by law be on the label?

MR. CONDER: Yes.

MR. BRYDEN: Whether he is a good manufacturer or bad his name must be there?

MR. CONDER: Yes.

MR. BRYDEN: Now the difficulty I see, and that I would like to raise for your comments is



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2 this: How does anybody except an expert in the field
3 know what is a reliable company and what is not?

4 Doctor Morrell, for example, told us that there were
5 some manufacturers, whose product he would not be
6 inclined to buy. That is fine for him. What about
7 me? I am not a director of the Food and Drug
8 Directorate. Is there anyway the public can be
9 protected?

10 MR. CONDER: Well, the protection, the
11 primary protection to the public right now is the
12 reliability of the manufacturer and what the
13 manufacturer does and what he produces.

14 MR. BRYDEN: How can the public know
15 whether he is reliable or not? They can't inspect
16 his facilities, and even if they did ---

17 MR. HUME: Aren't you assuming the public
18 are buying its product?

19 MR. BRYDEN: Let's put it in the terms
20 of the doctor. The doctor can't inspect the premises,
21 and unless he is a highly qualified man I would doubt
22 if he would be qualified to judge control procedures
23 in a chemical laboratory.

24 THE CHAIRMAN: Isn't the answer to this
25 experience over the years produces the desired result,
26 Mr. Bryden? Isn't that obvious?

27 MR. BRYDEN: No, I don't think it is
28 obvious because we have been told there are some drugs
29 that get on the market that are not reliable. Maybe
30 a good number of some.



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2 THE CHAIRMAN: You are talking now about
3 the control at the start?

4 MR. BRYDEN: Which is the guarantee of
5 quality, as I understand it. I believe that was the
6 submission of the Association, and I accept that.

7 THE CHAIRMAN: But to get to the point,
8 are we heading towards a suggestion that there should
9 be control -- we are concerned with the costs of
10 drugs. Now, the relevancy of this discussion would
11 be wastage or improper drugs being sold.

12 MR. BRYDEN: Well, even if we just confine
13 it to costs, Mr. Chairman, we were told by one of the
14 members of the Department of Health here in their
15 purchasing policy because I think of that experience
16 in their particular case, they are not setting up
17 certain testing procedures which will cost money, and
18 this arose, as I see it, out of the fact that you
19 can't be absolutely certain of the quality of a drug
20 that may be bought. There are instances where it is
21 not-----

22 THE CHAIRMAN: Does it arise----

23 MR. WHITE: May I comment on this?

24 THE CHAIRMAN: Some of these matters will
25 be matters of Committee to discuss itself as to
26 conclusion.

27 MR. BRYDEN: Well, if I could say ---

28 THE CHAIRMAN: Would you mind letting
29 me finish my statement, Mr. Bryden?

30 MR. BRYDEN: I haven't had a chance to



1
2 finish very many myself. If I may say, Mr. Chairman,
3 I have been interrupted persistently.

4 THE CHAIRMAN: Some of the matters which
5 will come before this Committee are facts. We hope
6 most of them are facts. They will then lead to an
7 orderly consideration of the facts by the Committee
8 in reaching the conclusions which we will find and
9 agree upon and which will go into our report. I do
10 not think this is the proper place for any of us,
11 including the Chairman, to argue the conclusiveness or
12 the finality of the evidence, because this Committee
13 has only at this stage reached, shall we say, the
14 real meat of the investigation that is before us.

15 I would put that to the Committee and the
16 interested parties in that fashion at this moment.
17 That is my only point. I do not think there is any
18 debate at the moment among the Committee about the
19 conclusiveness.

20 MR. BRYDEN: I don't suggest that.

21 THE CHAIRMAN: Proceed with the factual
22 examination, Mr. Bryden.

23 MR. BRYDEN: Well, ----

24 THE CHAIRMAN: There is a degree of
25 questioning which is acceptable in Committee work, and
26 I am not directing my remarks to you; I might direct
27 them to all the Committee who are here, Mr. Trotter,
28 Mr. Sutton, Mr. Boyer, and others. I think the first
29 thing to do is to get the facts out, and they we will
30 deal with the conclusions later. The questioning



1
2 must follow that line.

3 MR. BRYDEN: I think my questions were
4 all factual questions. On the other hand, I think
5 the next question I would like to put before this
6 witness, Mr. Chairman ---I think perhaps the opinions
7 of some of these people who are experts in the field
8 are worth canvassing.

9 Now, as a matter of fact, the line of
10 questioning I was following was just to lay a certain
11 basis for another matter that I would like to put
12 before the witness to see what he thinks about it.

13 THE CHAIRMAN: Would you like to indicate?

14 MR. BRYDEN: Yes, I will put it forward.
15 I may say first of all this has been an idea running
16 through my mind; in fact, I think it has already been
17 mentioned in this Committee and I want to get this
18 witness' views on it. It seems to me a grave problem
19 on quality control is that, or on reliability, shall
20 we say, is that you cannot necessarily rely on every
21 manufacturer in this field because they don't necessarily
22 all have adequate control facilities.

23 I am wondering if the problem does not get
24 back to the Federal legislation. The Food and Drug
25 Directorate, as I understand it, has authority to
26 inspect plants with a view to determining the adequacy
27 of their control procedures, but if they find the
28 procedures to be inadequate, they have no direct power
29 to do anything about it.
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2 * Now, I am wondering if this problem may
3 not stem back to that curious gap in that Act. Would
4 the situation be improved greatly if the Directorate
5 had authority to take action to require them in one
6 way or another, either through Court procedure or
7 whatever may be appropriate, to set up proper control
8 procedure or else get into some other business.
9 Would that solve the problem?

10 THE CHAIRMAN: What was the last? To
11 set up or?

12 MR. BRYDEN: Or to get out of the
13 business. To get into some other business if they
14 don't have adequate control procedures. It is not
15 uncommon in legislation affecting public health or
16 safety to have inspection powers, either issue orders
17 themselves or go to Court to get orders requiring that
18 proper procedures be followed. I don't know if you
19 have any comments on that, Mr. Conder. Do you think
20 that will help to rectify any better the situation
21 that may exist?

22 (* Reporter reads back question)

23 (Page 1361 follows)



1 THE CHAIRMAN: Before you answer
2 has the stenographer got that question?

3
4 (Reporter reads question)

5
6 MR. HUME: I must understand this
7 too, I am afraid as counsel. What is the problem
8 Mr. Bryden? I don't follow. I have lost the problem.

9 MR. BRYDEN: The problem is stated in
10 your own brief, unless I misread it, and it is that
11 there is a possibility of drugs getting on the market
12 that are not manufactured under proper quality
13 control procedures, and that that is a danger to
14 the public, which I believe to be the truth. It
15 also affects the Government in its purchasing
16 procedures and I am just wondering if, what I call
17 a gap in the legislation maybe the crux
18 of the matter.

19 MR. HUME: You are talking about a
20 tougher Act would solve the problem?

21 MR. BRYDEN: Well greater powers in this
22 particular area on the part of the Food and Drug
23 Director.

24 MR. CONDER: I think this is a
25 recognized point that some suppliers of pharmaceuticals
26 in this country do not maintain quality control
27 procedures to the extent that is done by other
28 companies in the industry.

29 The point which you made we have said
30 in our brief, that when we are dealing in human



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2 lives, as in this case, then we should insist
3 that these suppliers show evidence that their
4 products have been tested for quality standards
5 by a reputable and reliable laboratory preferably
6 located in this country.

7 MR. BRYDEN: Maybe I can simplify my
8 question by simply saying what do you mean by
9 saying "we should insist"?

10 MR. CONDER: That if a particular
11 manufacturer, and one which carries the connotation
12 of reliability by virtue of the amount of work
13 that he puts in to determining quality and effect-
14 iveness of a specific product which adds to his
15 cost of the product, this is quality control and
16 this should apply to other companies equally as
17 well. It is our opinion that our companies should
18 be so required.

19 MR. BRYDEN: By law?

20 MR. CONDER: By law. By regulations,
21 whichever you wish.

22 MR. BRYDEN: Has your Association
23 ever made any representations to the Federal
24 Government along these lines?

25 MR. CONDER: We are considering the
26 possibility on this.

27 MR. BRYDEN: Just on this section of
28 your brief, one more point. You referred to the
29 problem I mentioned a moment ago about the Health
30



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2 Department in Ontario setting up its own
3 testing procedures, which quite properly you
4 said will cost money.

5 Do you think they would be in a
6 position where they wouldn't have to do that if
7 there was proper incidents, as you say of quality
8 control?

9 MR. CONDER: That was the point in our
10 brief.

11 MR. BRYDEN: So again, if something
12 could be done to tighten up the Federal Act, it
13 is possible at least that that problem could be
14 obviated in Ontario?

15 MR. CONDER: I wouldn't know whether
16 it would be a tightening up of the Federal Act
17 or whether it would be a matter of bringing in
18 regulations. That would be something outside of
19 our particular jurisdiction.

20 MR. BRYDEN: As the situation stands
21 now is there anything else that the Department
22 of Health can do in that way?

23 THE CHAIRMAN: Which Department of
24 Health?

25 MR. BRYDEN: The Ontario Department
26 of Health through the Attorney General's lab.

27 THE CHAIRMAN: I just said which
28 Department. Be specific in your language. That
29 is all.
30



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2 MR. BRYDEN: Well is there any --

3 I thought it was clear from the context that I
4 was referring to the Ontario Department of Health.
5 Do you think they could do anything different
6 from what they are now doing in having the products
7 tested by the A.G.'s lab?

8 MR. CONDER: That is a very extensive
9 question.

10 MR. BRYDEN: They have to protect them-
11 selves?

12 MR. CONDER: Yes, they definitely do.
13 They can protect themselves by purchasing drugs
14 which come from reputable and reliable organizations.

15 MR. BRYDEN: Should they have a white
16 list or something, or a black list?

17 MR. CONDER: I would hesitate to say
18 that Mr. Bryden. That would be something for the
19 Department of Health of Ontario to determine itself.
20 Certainly the Provincial Government has had the
21 opportunity of sending inspectors, if they so desire
22 to all companies to inspect their facilities and
23 their laboratories in this respect. Our companies,
24 speaking on behalf of our companies, our companies
25 would certainly welcome them.

26 MR. BRYDEN: Well I suppose an
27 alternative the Health Department might be
28 asked was a matter of balancing the cost of
29 inspecting the premises. I have questions on
30 other subjects, Mr. Chairman, but Mr. White has some.



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2 THE CHAIRMAN: You needn't apologize
3 to me Mr. Bryden. Are you finished?

4 MR. BRYDEN: I would like to ask some
5 more but I will let Mr. White go ahead at the
6 moment.

7 THE CHAIRMAN: I would like some order.

8 MR. BRYDEN: If you want me to go right
9 through, well then I will.

10 THE CHAIRMAN: What is your view?
11 What other questions do you wish to ask? What
12 subjects?

13 MR. BRYDEN: I have some questions
14 on the matter of advertising and promotion, and
15 I have two or three, shall I say, miscellaneous questions.

16 THE CHAIRMAN: Well it is your turn
17 if you want to proceed, or do you want to defer
18 to Mr. White?

19 MR. BRYDEN: As long as you don't
20 say that I cannot come back again I will be quite
21 happy.

22 THE CHAIRMAN: I think you should
23 proceed and finish your questions.

24 MR. BRYDEN: Whatever you say. Now
25 you said in your brief, Mr. Conder, that various
26 promotional procedures, and as I recall I think
27 you called them information procedures in the
28 industry are the primary source of information
29 of the medical profession, and you make such
30 statements as, for example, at the bottom of page



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2 64: "advertisements in medical journals is
3 another important source of information for
4 the doctor, and those of you who have seen a
5 medical journal will know that these advertisements
6 are ultra-conservative in comparison to the
7 advertising used in consumer media or trade
8 publications of the durable goods industries."
9 Now I have looked through medical journals, and
10 I am just wondering on what basis you say that?
11 It seems to me that there is not very much
12 difference. There is one example in the Canadian
13 Medical Association Journal for a drug called
14 Selsun manufactured by Abbott described at the
15 bottom: ethical answer to a medical problem. And
16 the heading at the top is "end of her dandruff
17 worries for another week".

18 THE CHAIRMAN: Is that a drug problem?

19 MR. BRYDEN: That is what is described
20 in this ad.

21 THE CHAIRMAN: Is that a drug? I am
22 not trying to restrict you in any way but is that,
23 frankly, Mr. Bryden, a matter before the Committee?
24 Is that a drug that is prescribed by doctors?
25 Or is that a patent medicine?

26 MR. BRYDEN: It is manufactured by
27 one of the ethical manufacturers and is advertised
28 in the Medical Journal. The copy of the ad reads:
29 "She's pretty excited about her latest dandruff
30 treatment. Cured her neighbor for nearly ten days.
Why oh why do they tell the world about their



1 dandruff and never mention it to their doctor? Only
2 he can give them, the cure with a prescription for
3 Selsun. Only you can fill it. Do you have plenty of Selsun on hand?"
4 That is the total copy of the ad.

5 MR. BOYER: Is that a medical journal?

6 MR. BRYDEN: This is in the Canadian
7 Medical Association Journal for April 1st, 1959.
8 May I say, I did not select this issue because
9 of this or any other ad. I selected this issue
10 because there was an article in it I wanted to read,
11 and I looked through the ads.

12 THE CHAIRMAN: What is the name of the
13 company Mr. Bryden?

14 MR. BRYDEN: Abbott Pharmaceutical
15 Company.

16 THE CHAIRMAN: Are you able to answer
17 for Abbott Company Mr. Conder?

18 MR. CONDER: I am not able to answer
19 for Abbott Laboratories.

20 THE CHAIRMAN: Without again restricting
21 you, this is not a matter of debate between us at
22 all Mr. Bryden. If the witness cannot answer for
23 Abbott and Company then we will have to call Abbott
24 and Company. I think this is a good point to make
25 right at this time.

26 MR. WHITE: The only thing is, Mr.
27 Chairman, the man has made an assertion in the
28 brief on behalf of the Association so obviously
29 the members of the Committee can question some of
30 the assertions made.



1 MR BRYDEN: My only point sir --

2 THE CHAIRMAN: My understanding is
3 that the Association had retracted substantially
4 from its position yesterday afternoon.

5 MR. BRYDEN: I am not interested
6 in attacking Abbott or anyone else. I am only
7 interested in the assertion, for example, that
8 ads in medical journals "are ultra-conservative".
9 The only way that I can see that one can test that
10 is to start going through some ads.

11 THE CHAIRMAN: I would have to say that
12 is a fair question.

13 MR. BRYDEN: I won't go through a
14 whole lot of them, but there are others.

15 THE CHAIRMAN: What is the answer?
16 Let the witness answer. What is the answer?

17 MR. BRYDEN: I was going to give him
18 a few more to indicate that I didn't just pick
19 one of them. Perhaps that might be the proper
20 thing to do. Just taking this particular issue
21 of the Medical Association Journal, you will notice
22 that there is quite a lot of pretty flossy advert-
23 ising on all -- not all but most of the pages.
24 Another thing I might draw your attention to is
25 that in this Journal many of these ads are put
26 on special paper which is not the paper on which
27 the body of the Journal is printed, and I would
28 presume that the advertisers pay for this special
29 paper inserted.
30



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2 THE CHAIRMAN: You are delivering
3 a speech Mr. Byrden. Let's cut this thing down
4 and give us the question. What is the question
5 to the witness? And give the witness a chance
6 to answer.

7 MR. BRYDEN: Well I will let --

8 THE CHAIRMAN: This is a long speech
9 and you are giving evidence yourself and I have
10 no intention of letting you. It isn't proper.
11 It is absolutely improper for the members of the
12 Committee or judicial body to start delivering
13 evidence themselves. We are neutral. We don't
14 know anything. At least that is the Chairman's
15 position. Absolutely neutral. I don't know anything,
16 and speaking for some of the members of the Committee,
17 that is their position.

18 I think I should make that very
19 clear that speaking for myself, I have no preconceived
20 ideas about this subject matter whatsoever. I am
21 a layman. I am a poor practising lawyer trying
22 to get along in the world.

23 MR. BRYDEN: Mr. Chairman--

24 THE CHAIRMAN: Let me just finish
25 if you please.

26 MR. BRYDEN: I thought you had finished,
27 I am sorry.

28 THE CHAIRMAN: I have a long way to go
29 before I can match the time taken by you in asking
30 a question.



1 We are here to receive information which
2 will be achieved by asking individual direct questions.
3 After the information has been received, we have a
4 very efficient recording system and when it is recorded
5 we are delivered with copies of the transcript not
6 later than the following morning.

7 Speaking for myself, I cannot come to any
8 conclusions whatever until I have gone over the
9 transcript and reviewed it. I also cannot go over
10 yesterday's transcript this morning. It will take
11 me some six weeks, it may be months, before I can
12 come to the type of conclusion that I would like
13 to achieve.

14 That is why on numerous occasions I have
15 said this Committee is a fact finding body and about
16 six or eight or ten months from now if this Committee
17 is re-appointed we will then be coming to our dis-
18 cussions about the conclusions which we wish to
19 come to.

20 I think the questions should be directed
21 in the spirit in which I have described my views
22 in this matter.

23 MR. BRYDEN: I will say for myself that
24 I, too, am ignorant and I hope not to remain ignorant
25 on the subject. I submit to you, sir, that information
26 is valuable to this Committee regardless of where
27 it comes from and if we --

28 THE CHAIRMAN: I am not going to engage
29 in any type of debate with any member of the Committee.
30



1 I am directing the members of the Committee to ask
2 questions directly. Let us get the facts. Then
3 we will debate the results and the answers at a later
4 date. Please put your questions directly.

5 MR. BRYDEN: I submit, sir, if you make
6 a strict application of that rule you will reduce
7 the effectiveness of this Committee to the point
8 where it will be come a farce.

9 If it is impossible for a member of the
10 Committee dealing with the subject of advertising
11 on which certain assertions were made to bring in
12 samples of advertising and put them before the witness
13 to answer, it seems to me this Committee will find
14 out very little about this subject, because parties
15 coming in are eventually going to make their own
16 assertions.

17 THE CHAIRMAN: I have no intention of letting
18 any member of the Committee deliver speeches to be
19 added to his questions.

20 The question that you might have asked,
21 let me put it to you. I have a magazine in my hand.
22 Here is the advertisement. What are the witness's
23 comments in relation to his statement in his brief.
24 That is the question.

25 MR. BRYDEN: That is what I was trying to
26 get at.

27 THE CHAIRMAN: It took you too long to say
28 it. We are going to be here until 1972, as far as
29 I can see, if you cannot direct your questions in a
30



1 shorter manner.

2 MR. BRYDEN: It seems to me to be only
3 fair to call attention to the ads that I was talking
4 about and give him some of them to look at and see
5 what was in them.

6 THE CHAIRMAN: Will you please proceed,
7 Mr. Bryden.

8 MR. BRYDEN: I would like to bring in some
9 more samples of the advertising.

10 THE CHAIRMAN: Will you show them to the
11 witness?

12 MR. BRYDEN: I would like to put them
13 before him. These are not in the field of magazine
14 advertising. It is in the field of direct mailing
15 and maybe he might as well deal with it all at once.

16 I asked a practising physician in the
17 City of Toronto if he would for a two week period
18 save any promotional material and samples he got
19 through the mail and lend them to me, which he agreed
20 to do.

21 He did this for a two week period which
22 included the Thanksgiving Day Holiday so it was not
23 quite two weeks. This is the promotional material
24 that this particular doctor got, and these are the
25 unsolicited samples he got. He did not solicit
26 any of these. In this period of two weeks less one
27 day --

28 THE CHAIRMAN: I can bring a bigger box
29 than that.
30



1 MR. BRYDEN: No doubt you could, sir.

2 I did not bring it because of its size, but at any
3 rate this is what he got. There are one or two of
4 the ads here that I would like to put before the
5 witness.

6 THE CHAIRMAN: The witness has said - without
7 restricting you in any way because I have no preconceived
8 ideas as to the scope of our terms of reference,
9 but can this witness go into the details that you
10 propose to go into in the light of the explanations
11 made yesterday by the Association?

12 MR. BRYDEN: They make certain broad
13 assertions, sir.

14 THE CHAIRMAN: That is correct.

15 MR. BRYDEN: I want to ask about some of
16 the assertions. One of the assertions in the brief
17 which I would like to ask about is the one concerning
18 very conservative style advertising.

19 MR. HUME: May I rise to a point of order?
20 I think in all fairness what the brief says is that that
21 the advertisements in medical journals are ultra
22 conservation. I think the witness might well have
23 been asked if the advertisement for seltzen was
24 conservative. He might have said yes and he might have
25 said no, and the witness can answer for himself.

26 Mr. Bryden is now producing promotional
27 material about which the brief does not say anything
28 about, conservative or otherwise, and is coupling
29 with that the statement from the brief that the magazine
30



1 advertising in medical journals is conservative.

2 MR. BRYDEN: I agree with you. I should not
3 have brought this in at this point.

4 THE CHAIRMAN: Well then, will you remove
5 the material.

6 MR. BRYDEN: I want to ask a couple of other
7 questions.

8 MR. WREN: On a point of order. I would
9 like Mr. Bryden -- he is using the name of a qualified
10 medical doctor and he should state the name of the
11 doctor who gave him this material.

12 MR. BRYDEN: I am not prepared to do that.

13 MR. WREN: All right. He is a rather
14 irresponsible person to put the hands of a layman
15 drugs which could be potentially dangerous.

16 MR. BRYDEN: On that point, Mr. Chairman --

17 MR. WREN: I think the medical council
18 should know what that man is.

19 MR. BRYDEN: Here is one that a drug company
20 does up, sir the material is a sample --

21 THE CHAIRMAN: What is it? Let us be frank.
22 I take it -- gentlemen, I take this Committee work
23 and my responsibility as chairman in a rather serious
24 vein. Maybe I am taking them too seriously.
25 If I am, maybe I will get down to the level of some
26 other people, but I regard this as a rather extremely
27 serious matter involving the reputation of companies,
28 thousands of employees who are employed in these
29 industries, the health of the nation, the cost of drugs
30



1 to the Province, the legitimacy of the local pharmacy,
2 and his contribution to the community. All these and
3 similar factors keep me awake at night. I was up
4 until 2:30 o'clock this morning going over some of
5 these matters, and I am rapidly coming to the conclusion
6 that maybe I, as chairman, am taking the matter too
7 seriously in the light of some proceedings. If this
8 is so, I will be glad to be told.

9 I think it is absolutely improper, Mr.
10 Bryden, of you to come in and throw a package of stuff
11 on the table in the light of what was said yesterday
12 and then today, and then to say, "well, I have brought
13 it in at the wrong time." What kind of procedure
14 is that?

15 MR. BRYDEN: There is nothing improper
16 about it, either. I agree I made a mistake on the
17 question of advertising in the medical journals,
18 but they are making other claims in the brief to
19 which it has relevance. I made an error for which
20 I apologize.

21 THE CHAIRMAN: Let us not have any repetition
22 of your error.

23 MR. BRYDEN: This applies to the next
24 question I have.

25 THE CHAIRMAN: Thank you. Let us proceed
26 with the next question, Mr. Bryden.

27 MR. BRYDEN: I would have finished if
28 I were permitted to proceed.

29 THE CHAIRMAN: Please proceed with your next
30



1 question.

2 MR. BRYDEN: I am ~~not taking any orders~~ ^{not taking any orders}. I
3 will handle the matter in the best way I know how,
4 and if I can get assistance from the Chair, I appreciate
5 it.

6 I was on the question of advertising in
7 medical journals and I would like to ask the witness
8 if the purpose of this advertising is mainly to
9 communicate information in medical journals, why
10 it is necessary to insert high quality paper which is
11 different from the paper on which the standand
12 information on the journal is communicated.

13 MR. HUME: Can we see the advertisement,
14 Mr. Bryden?

15 MR. BRYDEN: I would be glad to. I borrowed
16 this from the physician, but I would be glad to
17 let you have it. There are several on high quality
18 paper, very much higher than the average. The
19 one I specifically called attention to is on the other
20 side of the sheet.

21 THE CHAIRMAN: Is this a matter of significance?
22 Some of the briefs submitted to the Committee have
23 hard board covers and others have ordinary paper
24 covers. Is there any significance as to that?

25 MR. BRYDEN: I think there is great significance
26 from this assertion that all the companies are trying
27 to do is to communicate information to the profession.
28 This is promotional material which is not informative
29 material. It is definitely an eye catcher.
30



1 MR. HUME: My objection is simply this.
2
3 The brief does not say that the sole purpose of
4 advertising is for information. The brief says
5 that advertisements in medical journals, which if
6 I was in the drug industry I would be putting into
7 sell my product, is an important source of information.
8 Mr. Bryden is now turning that around to indicate
9 that while we use an eye catching advertisement,
10 if the sole purpose is for information, and the sole
11 purpose is to sell drugs, and the advertisement is
12 a source of information. I base my objection on
13 the basis upon which Mr. Bryden is questioning the
14 witness on, "Why do you use a good grade of paper
15 is your sole purpose is to give information." The
16 brief does not say that.

17 MR. BRYDEN: If it is conceded in these
18 ads that the primary purpose is not to convey
19 information, I would not pursue it any further.
20 If that is conceded, I do not know.

21 MR. HUME: I do not know whether the witness
22 can concede it without checking the ad. Maybe there
23 is some information about the ad.

24 MR. BRYDEN: As a matter of fact, that is
25 the other question I wanted to get in. There were
26 three questions. This group of journals I have gone
27 through is only a small sample of the total, but a
28 great many of the ads give very little information,
29 indeed, under the name of the product, and some
30 claims about them. Would you call that informational



1 advertising?

2 I can give you other samples. Here is one
3 called "Frosst weather forecast." Here is another
4 one, November, December, and inside are some weather
5 charts and on the back is --

6 THE CHAIRMAN: Have you got a copy for me?

7 MR. BRYDEN: You can have that, sir.
8 On the back is a promotion of something called
9 "Ostacco drops".

10 MR. CONDER: Mr. Bryden --

11 THE CHAIRMAN: Excuse me, Mr. Conder. What
12 distribution did this have?

13 MR. BRYDEN: All I can say is the man
14 gave them to me.

15 THE CHAIRMAN: This came from your doctor?

16 MR. BRYDEN: He is a medical practitioner
17 in the City of Toronto. I can see no reason why
18 he would have got it any more than anything else.

19 THE CHAIRMAN: Did he object to this piece
20 of literature?

21 MR. BRYDEN: He did not go through the
22 material item by item. He objected to the way this
23 arose. As you know, I was laid up a while ago
24 and he objected, in talking to me, to the material
25 in general.

26 THE CHAIRMAN: Let us deal with this
27 specifically. Did he object to this one?

28 MR. BRYDEN: He did not have an opportunity
29 of expressing an opinion on it.
30



1 THE CHAIRMAN: What did he say about this
2 particular item?

3 MR. BRYDEN: He did not say anything about it.
4 There is nothing different in this field, if this
5 is what I know as a weather forecast in industry.
6 From my own personal experience I know that anyone
7 selling textiles, for instance, takes weather
8 forecasts into account, whether it is going to be
9 a mild winter or a hot summer, or a cold summer,
10 having to do with their own production, and it is
11 proper.

12 From my point of view this is a very proper
13 businesslike approach to the merchandising and
14 production of their products. Is there any objection
15 to these weather forecasts in your mind, Mr. Bryden?

16 MR. BRYDEN: I am just asking what medical
17 information that communicates to the profession.

18 THE CHAIRMAN: The broader presentation
19 tends to smear anything of this sort, and I think
20 we must be very careful. It is not our duty in
21 this Committee to smear or slander or criticize anyone.
22 We are here to receive facts. I want facts about
23 this piece of literature. Are there any? Have you
24 any questions about it?

25 MR. BRYDEN: The matter I would like to
26 get cleared up is I think a lot of this promotion
27 is not fundamental to communicate information at all
28 and that hits back on the price of drugs and on the prac-
29 tice of medicine, and I just want to find out how
30



1 much of it is information and how much is straight
2 promotion to get you to buy one brand rather than
3 another. If you take it from that standpoint, it
4 is straight promotion.

5 THE CHAIRMAN: What is wrong with promotion?

6 MR. BRYDEN: I am not saying anything is
7 wrong.

8 THE CHAIRMAN: What is wrong?

9 MR. BRYDEN: In this industry it could
10 have a lot of serious consequences because a drug
11 can be over promoted which could be very serious
12 for a patient. There are instances of that on record.

13 THE CHAIRMAN: What drug is being promoted?

14 MR. BRYDEN: I am not talking about this
15 specific one, but talking about the drug prolonthesis.

16 THE CHAIRMAN: Was that a Frosst product?

17 MR. BRYDEN: I am not picking out any
18 particular company, but I know of Carter's Little
19 Liver Pills in the United States. This was promoted
20 as being non-habit forming, and it was found to be
21 habit forming.

22 THE CHAIRMAN: What we are getting down to,
23 and we might as face the issue in the Committee,
24 we are getting down to a question of whether we
25 are going to have a socialized government or not.
26 That is the basis of your argument, whether the govern-
27 ment is going to take over the dissemination of
28 information about all drugs.

29 MR. BRYDEN: I never even suggested it.
30



1
2 MR. WHITE: On a point of order, Mr.
3 Chairman, I have defended Mr. Bryden's right to
4 question the assertions of the advertisements in
5 medical journals. On this point, it seems to me
6 that if Mr. Bryden wants to put material such as this
7 into evidence and into the record, that he should
8 appear as a witness or have his counsel appear as a
9 witness and be subjected to the cross-questioning of
10 our counsel and the interrogation of our auditor and
11 the members of the Committee. This is not proper
12 procedure, in my opinion, for a member of the Committee
13 to be trying to read all this stuff into the evidence.

14 MR. BRYDEN: I submit to you, sir, that
15 if anybody, and I don't care who it is, comes in with
16 assertions -- very broad assertions, I think it is
17 fair enough to test those assertions.

18 MR. WHITE: What assertions are you
19 testing?

20 MR. BRYDEN: Well, the one about the
21 ultra-conservative nature of them -- I have dropped
22 that. I am trying to find out to what degree this
23 advertising is informational and what the nature of
24 the information is that is communicated and to what
25 degree it is promotional?

26 MR. BOYER: Mr. Chairman, on Mr. White's
27 point of order, I feel that several of the members of
28 the Committee would like to ask questions concerning
29 this material. Now, is Mr. Bryden the one we are
30 going to ask questions of? I do not think that is



1 proper.

2 THE CHAIRMAN: I think he must produce---

3 MR. WREN: That is the point of order
4 raised a while ago, but you did not chose to rule on
5 it. The point is this, that some unknown medical
6 doctor provided this information, or this material,
7 to a member of the Committee. Now, that doctor, in
8 his professional capacity, should have, if he is
9 interested, as it would appear -- he should have the
10 courage to appear before this Committee himself as a
11 professional man and give a professional opinion about
12 it.

13 THE CHAIRMAN: As other doctors have done.

14 MR. WREN: As other doctors have done.
15 I think it is a breach of his ethics if he has proceeded
16 ---

17 MR. BRYDEN: Mr. Chairman, I submit that
18 a very serious charge and that you should reconsider;
19 but, I would point out to you that this material, it
20 is all readily identifiable. It does not depend
21 on this mediacal pratitioner or anybody else for its
22 authenticity. It is identifiable on the face and
23 that is a complete red-herring of Mr. Wren's.

24 THE CHAIRMAN: Let me say this: I do
25 not think we should ever let this Committee get into
26 the realm of receiving anonymous letters and taking
27 them and attaching any value to them.

28 MR. BRYDEN: This is not anonymous.

29 MR. WREN: I submit it has no more
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strenth than an anonymous letter.

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THE CHAIRMAN: Would you please let me

finish. A lot of people criticise lawyers, but the

rules of evidence have been established, according

to our practice, over some hundred years, commencing

from the time when there were no rules of evidence,

and experience has shown that the best evidence is

the direct evidence -- first-hand. It is better

than hearsay and I think with a subject of this

importance we should have the best evidence. And the

point is we are now -- I have to keep in mind the

limitations that were imposed on us by this Association

yesterday afternoon in its brief, which will take us

probably into the realm of the individual companies.

I think you are ignoring that point so far,

Mr. Bryden. We will come into the question of the

individual companies at a subsequent date; but, the

best evidence is the most direct evidence, Mr. Bryden.

MR. BRYDEN: Well, Mr. Chairman, you

have refused to hear this brief which is not in the

evidence ---

THE CHAIRMAN: Somebody has volunteered

something. Do you think I am going to throw out this

brief from the Pharmaceutical ----?

MR. BRYDEN: No. But, it is not evidence

in any sense.

THE CHAIRMAN: But, it is a brief and

we just take it for what it is worth.

MR. BRYDEN: That is fine, but we can



1

2 take this for what it is worth.

3

THE CHAIRMAN: Well, it is not worth

4

very much. I want some direct evidence on this

5

advertising, and it may be that the cumulative effect

6

of the advertising is too great and that it is wrong.

7

How is that? It may be it is absolutely wrong.

8

Maybe they are going too far with their advertising.

9

Maybe they are spending too much money on colour spreads

10

and on special page insertions on medicines. That

11

may very well be; but, I do not think this is the kind

12

for us to go to the anonymous....

13

MR. BRYDEN: No, Mr. Chairman, this

14

may be the better procedure. I still believe, with

15

deference, that you are treating this far too much as

16

if it were a court of law, from time to time.

17

THE CHAIRMAN: That may be your opinion.

18

As long as I am chairman, I will run it to the best of

19

my ability.

20

MR. BRYDEN: And as long as I am a member

21

I will express my opinions unless I am told to withdraw

22

them. But, perhaps the solution might be, to this

23

impasse we seem to be in, to get somebody, some

24

independent person to make a detailed survey of the

25

whole advertising in the industry, bringing in samples

26

of this kind. If you don't want to accept this as

27

a true promotion of hoax pharmaceuticals, okay.

28

Their name is right on it.

29

THE CHAIRMAN: I will tell you what I

30

object to. I am not talking about the content, merit



1
2 or deficiency of any of the material you are advancing.
3 I am talking about the procedure. I think it is
4 an undesirable thing to have a member of a committee
5 to come in with a box and dump it on the table.

6 MR. BRYDEN: I thought that as a member
7 of the Committee I was carrying out my duty of trying
8 to acquire as much information as I could.

9 THE CHAIRMAN: I may tell you that
10 some of the rest of us have done at least as much
11 work as you have.

12 MR. BRYDEN: I have absolutely no doubt.

13 THE CHAIRMAN: Well, let us leave the
14 matter there.

15 MR. BRYDEN: When I find matters in my
16 research such as they are today which do not seem
17 to jibe at all with what is in the brief, I would
18 like to get to the bottom of it. I am not saying I
19 am right and they are wrong.

20 MR. HUME: I cannot let a statement like
21 that go directly without registering my objection.
22 I believe that there is no lack of jibing by reason
23 of the fact that Mr. Bryden -- I am sure that he has
24 selected one ad...

25 MR. BRYDEN: No. There is a lot of those.

26 MR. HUME: I have been through this
27 thing as you have been discussing this matter and in
28 most of the ads -- I would like Mr. Bryden to look
29 them over and make whatever statement he would like,
30



1
2 but most of the ads have quite a bit of information
3 about dosage and content and, so, I submit that this
4 is a source of information.

5 MR. BRYDEN: I would like to follow up
6 on that. I do not think I ever denied...

7 THE CHAIRMAN: Are you debating the
8 matter by way of conclusion or to elicit some fact?

9 MR. BRYDEN: I am having a little diffi-
10 culty in following any continuous line. Therefore,
11 if my procedure is awkward, I apologize for that.
12 But, I still think the degree of advertising is
13 in your department and all technicalities about
14 how information is brought in is not important, in
15 my mind; but, one question I would like to ask Mr....

16 THE CHAIRMAN: I would say this is the
17 most fortunate witness that ever appeared before
18 a Committee. He has never had a chance to answer
19 anything. If he keeps quite, he won't be forced to.

20 MR. BRYDEN: Don't lay the blame for
21 that on me, Mr. Chairman.

22 THE CHAIRMAN: Well, I do.

23 MR. BRYDEN: Well, I don't think that
24 the blame should fall on me. I think that you are
25 interrupting me...

26 THE CHAIRMAN: Mr. Bryden, that is the
27 last remark I will hear from you on this subject.
28 Proceed with your examination.

29 MR. BRYDEN: Well then, may I proceed
30



1 without further interruption?

2
3 THE CHAIRMAN: I said proceed with
4 your examination. You have been acting as counsel
5 before numerous legal judicial tribunals and you
6 have had a lot of experience and you should know
7 all about the correct procedure and please demonstrate
8 it before this Committee.

9 MR. BRYDEN: Mr. Chairman, I think you
10 are giving yourself greater powers than belong to
11 the Chairman.

12 THE CHAIRMAN: You just proceed with
13 your examination and get to the meat, rather than
14 advancing some special political philosophy.

15 MR. BRYDEN: I am not advancing any
16 philosophy. On a point of privilege, I submit that
17 the Chairman has no right to impute motives to
18 any member. I am bringing up matters. I am not
19 advancing any philosophies. I have a philosophy,
20 but I am not bringing up the philosophy, and I submit...

21 THE CHAIRMAN: We will adjourn for
22 five minutes.

23
24 ---Short recess.

25
26 Page 1394 follows...
27
28
29
30



1
2 --- On resuming after short recess

3
4 THE CHAIRMAN: Well, are we ready to
5 resume, everyone?

6 MR. SUTTON: Mr. Chairman, I feel as a
7 member of this Committee that we have reached an
8 impasse. I feel that Mr. Conder has been on the
9 witness stand for two and a half days, and in our
10 agenda we were to hear this Association for the first
11 two days, and Mr. Gilbert was to be the witness today.
12 He has been sitting patiently here all morning.

13 I think that ultimately we will have to
14 hear this Association at a later date, and that the
15 proceedings, these proceedings, should be wound up
16 immediately and Mr. Gilbert called. If we could put
17 that to a vote of the Committee, I make that in the
18 form of a motion.

19 MR. WHITE: Speaking to that motion
20 I would be most reluctant to see the witness dismissed
21 before I asked him a number of questions which pertain
22 to the brief and which won't be nearly as pertinent
23 or interesting if they are asked in six months' time.

24 MR. SUTTON: All this information has
25 been given to this Committee by the Secretary of the
26 Association in the presence of his counsel, also an
27 economist, and we have to ultimately get the information
28 we need from the various companies, various members
29 of this Association. The proceedings -- the Committee
30 is not gaining anything from the questions that are



1
2 being asked this morning.

3 MR. WHITE: Surely to goodness one member
4 of the Committee should not be excluded from asking
5 questions. Everybody else has had his turn.

6 MR. BRYDEN: Maybe I could offer a
7 solution to this problem. If it is understood this
8 Association may come back at a later time, I would
9 be prepared to defer any further questions I have and
10 let Mr. White ask his questions now, and that might
11 solve the problem.

12 I would hate to see Mr. White excluded
13 entirely. If some members of the Committee feel time
14 is running on, I am willing to stand aside for him
15 for I have certainly got to admit I have had a fair go
16 at it. There are some questions I would still like
17 to ask.

18 MR. SUTTON: I would make that in a
19 form of a motion. If there is a seconder I would like
20 to see the motion put, and if there is not a seconder,
21 of course the motion will be withdrawn.

22 THE CHAIRMAN: You don't need a seconder
23 on the Committee.

24 MR. TROTTER: I think Mr. White should
25 have an opportunity to ask his questions, in my view.

26 MR. BRYDEN: Could I ask an amendment
27 that the witness be relieved -- the witness stand
28 down after Mr. White has had an opportunity.

29 THE CHAIRMAN: Let's establish this.
30 I would not restrict any member of the Committee or



1
2 any interested party in this room from asking questions.
3 Everyone has a right to be heard. Now, I must
4 therefore approach the matter in this fashion: Have
5 you any other questions you wish to ask, Mr. Bryden?

6 MR. BRYDEN: Sir, if it is understood
7 that the Association may come back, I will defer any
8 more I have until then.

9 THE CHAIRMAN: Mr. White, how long would
10 your questioning take?

11 MR. WHITE: Well, the questions themselves
12 while fairly numerous are short and they call for a
13 short factual answer. I would think I could get through
14 them in half an hour or less if the answers are not
15 unduly long.

16 THE CHAIRMAN: Well then, let's look at
17 the procedure. We have counsel and other interested
18 parties who may wish to ask some questions of the
19 witness. I think we should proceed, and with respect,
20 as I see it, put Mr. Gilbert on immediately after the
21 lunch hour if not shortly after the lunch hour. I
22 would like to hear what Mr. Gilbert has to say. He
23 has prepared a brief.

24 MR. SUTTON: I would be glad to withdraw.---

25 THE CHAIRMAN: Would that meet your
26 approval, Mr. Sutton?

27 MR. SUTTON: Yes.

28 THE CHAIRMAN: I would like to accomplish
29 as much as we can with unanimity. Well then, Mr. Bryden,
30 you are withdrawing and discontinuing?



1
2 MR. BRYDEN: Yes, sir.

3 THE CHAIRMAN: Mr. White?

4 MR. WHITE: Will you refer to your
5 copy of the brief which you presented to the Committee?

6 MR. CONDER: Yes.

7 MR. WHITE: Have you got a copy?

8 MR. CONDER: Yes, it is the same.

9 MR. WHITE: On page 25, the lower left
10 hand corner you mention a hundred and fifty-five
11 million dollars worth of drugs were shipped in 1958.
12 Would I be correct in thinking that is the manufacturers'
13 selling price?

14 MR. CONDER: This would be the amount
15 of drugs shipped, manufacturers' selling price.

16 MR. WHITE: Could you estimate for the
17 Committee the portion that might have been shipped to
18 Ontario and sold to Ontario consumers?

19 MR. CONDER: I cannot.

20 MR. WHITE: Well, would you approximate
21 them? Wouldn't it be about half?

22 MR. CONDER: Oh, I honestly could not
23 say that.

24 MR. WHITE: On page 28, the third
25 paragraph contains the sentence:

26 "I venture that the savings realized by
27 purchasing imported drugs are not as great
28 as the taxes which would have been gained
29 from Canadian companies and their
30 employees supplying this same material."



1
2 Have you any evidence to submit in support of that
3 assertion?

4 MR. CONDER: No, I haven't, Mr. White.

5 MR. WHITE: This is your opinion?

6 MR. CONDER: It is just a personal
7 opinion.

8 MR. WHITE: Page 29, -- could you tell
9 us what portion of the drugs manufactured in Canada
10 are made by members of your Association. I think you
11 said 80 to 90 per cent yesterday and Mr. Hume said
12 90 per cent. Has that figure not been determined?
13 May I say that it cannot be determined from the figures
14 submitted because the DBS figures are for 1958 and
15 previous, and all your figures are for 1959, but you
16 must know the percentage represented by your members.

17 MR. CONDER: I don't know the percentage
18 as it stands right now at this present time. I used
19 the term 80 to 90 per cent to give a spread based on
20 projections which may have been made over the past
21 years.

22 MR. WHITE: Well, Mr. Chairman, might I
23 ask through you that the auditor, that our accountant
24 procure that information? It is readily available
25 I am sure.

26 Pages 30 and 31, half way down page 30,
27 sales of other products, \$16,903,903. What would those
28 other products include? Would they include surgical
29 supplies et cetera?

30 MR. CONDER: Yes, they would include



1
2 surgical supplies and possibly baby formulae.

3 MR. WHITE: On page 31, expense account
4 No. 4, materials, is shown as including packaging.
5 Could you tell us what percentage or what portion of
6 the forty-two million dollars was packaging?

7 MR. CONDER: No, I cannot. That would
8 vary from company to company.

9 MR. WHITE: Could you tell us what the
10 average is for your Association?

11 MR. CONDER: We have no average for the
12 Association on that.

13 MR. WHITE: Item No. 7, depreciation,
14 1.6 per cent of sales seems to be unusually low, and
15 it leads me to wonder if there is very much manufacturing
16 equipment actually in Canada or if most of the
17 Canadian manufacturers so-called are simply processing
18 raw drugs that are brought in from other countries.
19 Could you tell me the value of the equipment owned
20 by members of your Association?

21 MR. CONDER: I don't have the figures
22 with me, but I will be glad to get them.

23 MR. WHITE: Could you tell me if this
24 survey on pages 30 and 31 constitutes all of the
25 information collected by your Association?

26 MR. CONDER: Yes, that is correct,
27 with the exception of two companies which I believe
28 from our auditor did not balance out, and we didn't
29 want to put them in. It would throw out the balance.

30 MR. WHITE: Was there information



1
2 collected that was not included in the presentation
3 to the Committee?

4 MR. CONDER: No, outside of the two
5 companies I mentioned.

6 MR. WHITE: Were balance sheet figures
7 offered?

8 MR. CONDER: No, sir, they were not.

9 MR. WHITE: Now, Items 9 and 10
10 constitute profit, and I have determined that the profit
11 as a per cent of sales is 6.2 per cent and that the
12 profit as a per cent of net worth is 13.8 per cent.
13 Am I correct in thinking that those two profit ratios
14 are considerably less in Canada than they are in the
15 United States?

16 MR. CONDER: Yes, I believe that is
17 correct.

18 MR. WHITE: In your capacity as an
19 expert in the field rather than as manager of the
20 Association, would you think that the profits are
21 lower in part because of research charges and other
22 charges made by the American head offices or foreign
23 head offices of their Canadian subsidiaries?

24 MR. CONDER: It would be very difficult
25 indeed to attempt to pin it down to one specific point
26 such as that. There are many factors that come into
27 consideration such as the higher cost of doing business
28 in Canada by virtue of the diversity of the market
29 and other similar factors.

30 MR. WHITE: Can you tell us how the 6.2



1
2 per cent profit on sales realized by your Association
3 members compares with the American average?

4 MR. CONDER: I'm sorry, I don't have that
5 figure with me.

6 MR. WHITE: Could you tell us ---

7 THE CHAIRMAN: Could he get that figure?

8 MR. CONDER: Yes, I will be glad to get
9 it.

10 THE CHAIRMAN: I am glad you raised that
11 question because late last evening in going over these
12 matters at home I was reminded again from my file our
13 terms of reference include -- must necessarily include
14 comparisons with other jurisdictions, and the obvious
15 one of course would be the United States. I think
16 this applies to most phases of our inquiry, as a matter
17 of fact. You might even expand your question to the
18 United Kingdom and even European countries.

19 MR. WHITE: I will do that, Mr. Chairman,
20 and at the same time could the Association inform us
21 what the comparable figures are for those other
22 countries? Net profit as a percentage of net worth,
23 as well as a percentage of sales?

24 MR. CONDER: We will attempt to get that
25 information.

26 MR. WHITE: At page 35, the third
27 paragraph:

28 "Looking at the industry's average profit
29 from the patient's viewpoint, the 6.2 per
30 cent is based on the manufacturer's sales



1
2 dollar. The percentage of manufacturer's
3 profit paid by the patient works out to
4 slightly more than 3¢ of the retail sales
5 dollar."

6 I submit, Mr. Chairman, that the profit is 6.2 per cent
7 of sales notwithstanding that assertion, and that the
8 profit is 13.8 per cent of net worth, and that the
9 3 per cent figure is misleading the reason being that

10 ----

11 THE CHAIRMAN: That figure is shown in
12 what item?

13 MR. WHITE: The middle of page 35.

14 THE CHAIRMAN: Yes.

15 MR. WHITE: At page 38, the last paragraph;
16 "The per capita expenditure on all types
17 of research in 1955, was \$26. for the
18 United States, \$22. for the United Kingdom
19 and \$12. for Canada."

20 Is this expenditure on drug research only?

21 MR. CONDER: No, that is all forms of
22 scientific research.

23 MR. WHITE: Would that research figure
24 include research charges made to Canadian subsidiaries
25 by foreign owners? By way of example, would it
26 have included the total amount spent by a foreign-
27 controlled drug manufacturer on behalf of Canadian
28 subsidiaries as set forth on page 41 in the amount of
29 \$2,614,900 in 1959?

30 MR. CONDER: I couldn't say that because



1
2 that information was not contained in the original
3 reference.

4 MR. WHITE: On page 40, the illustration
5 at the bottom of the page summarizes the return from
6 22 companies.

7
8 (Page 1405 follows)



1 MR. WHITE: Are those 22 companies all
2 members of your Association?

3 MR. CONDER: Yes, they are.

4 THE CHAIRMAN: Mr. White, might I with
5 respect ask -- I wonder if you could ask a question
6 on this point: did the Association receive any informa-
7 tion from non-member companies?

8 MR. WHITE: That is actually the point. I was
9 trying to make Mr. Chairman, thank you. Did the
10 Association receive information in this exhibit, or
11 any other exhibit in the brief from non-member companies?

12 MR. CONDER: No, we didn't.

13 MR. WHITE: On Page 45, dealing with control,
14 the middle of the page: "The proper place to test
15 and ensure the quality of a drug is at its source
16 of manufacture, during the time it is being made."

17 As we have been informed by a number of
18 important civil servants, and members of the profession,
19 there are no minimum quality control regulations
20 in existence in Canada now. No Governmental regulations.
21 You have referred to certain quality control standards
22 established by your Association as a pre-requisite
23 for membership, if I understand correctly?

24 MR. CONDER: Yes. They are not exactly standards
25 which might apply in the company. They are merely
26 standards for membership which we have applied, to
27 ascertain.

28 MR. WHITE: Could you tell us what the
29 Association requires in the way of quality control
30



1 facilities before an applicant is admitted to membership?

2 MR. CONDER: A company must answer questions
3 which I stated in the brief. The number of questions
4 which are contained in that.

5 MR. WHITE: Where are they?

6 MR. CONDER: On Page 72 and on Page 73 at
7 the top.

8 MR. WHITE: Now these questions ask an
9 applicant to describe quality control facilities
10 and methods, but they do not establish any minimum
11 standard. Am I correct in thinking that the management
12 or the executive of the Association has the arbitrary
13 right to decide whether or not the applicant's answers
14 qualify him for membership?

15 MR. CONDER: Yes, but based on the experience
16 that they have in this particular field.

17 MR. WHITE: It is not based on any set
18 of regulations?

19 MR. CONDER: Not on a set of regulations,
20 as such, because the type of equipment and the
21 method of analysis, and other factors could conceivably
22 vary from company to company.

23 THE CHAIRMAN: Mr. White it would then appear
24 that this is a voluntary Association of Companies,
25 or individuals, having a qualification of being in
26 the drug business, speaking generally, but the charac-
27 teristic would then appear to be, and I would like
28 to ask you if I am right in this that it's not
29 an Association of everyone in the business. It's a
30



1 group having its own standards of admission.

2 MR. WHITE: The regulations, I suggest,
3 Mr. Chairman are not unlike a private club where you
4 state your experience and your qualities or qualifications
5 and then the executive says "Well yes you can join"
6 or "No you can't".

7 THE CHAIRMAN: I would think that would
8 seem to be clear.

9 MR. WHITE: Now turning to Page 51 and 58,
10 you have quoted: "Resulting comparisons showed that
11 'the differences in the number of products meeting label
12 claim of those companies with control and those without
13 control are striking. Two out of 128 or 1.5 per cent
14 of the controlled products tested were deficient
15 while 166 out of 313 or over 50 per cent of non-controlled
16 products did not meet the labelled requirements in
17 one or more vitamins.'"

18 Turning to Page 78, I see the reference is
19 to J.A. Campbell, Could you tell this Committee who
20 Mr. Campbell is?

21 MR. CONDER: I believe that Dr. Campbell
22 is with the Department of National Health and Welfare
23 in Ottawa.

24 MR. WHITE: Was this an assertion made
25 in a newspaper report or where would you have obtained
26 this quotation?

27 MR. CONDER: This was taken from the Canadian
28 Medical Association Journal and was a rather comprehensive
29 report made by Dr. Campbell in that publication.
30



1 MR. WHITE: We were informed by the director
2 of the Food and Drug Directorate that there had
3 been 60 some odd rejections of drugs by his inspectors
4 in the year ending March 31st, 1960.

5 Could you tell me how many of those pertain
6 to the member companies in your Association?

7 MR. CONDER: We don't know that Mr. White
8 because that information is not made available to us
9 by the Food and Drug Directorate.

10 MR. WHITE: On Page 53 you have stated:
11 "...we should insist that these suppliers show evidence
12 that their products have been tested for quality
13 and standards by a reputable and reliable laboratory,
14 preferably located in this country." I would ask
15 Mr. Chairman that the Association submit their
16 detailed and specific suggestions on this point to
17 the Committee before it meets next spring.

18 It seems to me to be a very important factor
19 in the cost of drugs, and if you don't mind my
20 speaking to this subject for just a minute, at the
21 present time we have been informed the minimum
22 standards established in this country for drug
23 quality are such that the Director of the Food
24 and Drug Directorate would be reluctant to purchase
25 some of the drugs being sold through the retail stores.

26 We have had evidence from the Department
27 of Health and others that they cannot accept the pro-
28 duct of some manufacturers. That is not exactly
29 right. That they have had to test their own because
30



1 they cannot rely on the uniform quality of drugs
2 that are bought by tender. To buy drugs by competitive
3 tender, an institution or Department of Government
4 must buy by generic name. If they buy it by brand
5 name obviously there is only one source. If they are
6 to buy by competitive tender, therefore, the standards
7 of production or the standards set for distributors
8 in the country must either attain a certain minimum
9 quality standard, or the purchaser has to test
10 his own.

11 I think that if a greater degree of competition
12 is to be achieved, particularly with regard to
13 the Departments of Government, which is our most immediate
14 concern, that the minimum quality of drugs has to
15 be formally established and enforced, and I would
16 hope that this Committee would make certain recommenda-
17 tions in its final report.

18 In order to consider that very vexing problem,
19 I would ask that the Association give us the benefit
20 of their experience in possibly licensing regulations
21 that might be established by Government.

22 THE CHAIRMAN: As a matter of fact, on
23 that point Mr. White it was my conclusion from the
24 evidence of the Commissioner of Patents, Mr. Michel
25 that it is lack of frequency of registered licensing
26 agreements that created a reasonable inference that
27 there seems to be a certain degree of private negotia-
28 tions in licensing that never come to the attention
29 of the Department.
30



1 MR. WHITE: Well on patent licences,
2 yes, but I am not thinking of patents now. At the
3 present time, as I understand it, the Food and Drug
4 Directorate does license drug manufacturers for
5 the production of certain limited range of drugs,
6 whether that manufacturing company is located in
7 Canada or in some foreign country.

8 THE CHAIRMAN: Yes.

9 MR. WHITE: I am wondering if the licensing
10 regulations should be broadened by the Federal Government.
11 If that is out of our jurisdiction, whether Ontario
12 should consider licensing drug manufacturers.

13 MR. HUME: Mr. Chairman, so that I might
14 understand Mr. White's point, and we should be pleased,
15 of course, to do that, I presume Mr. White doesn't
16 want merely a general statement of what we think
17 the regulations ought to contain. You would like
18 to see actual draft regulations?..

19 MR. WHITE: Yes, I would like something
20 very specific and precise.

21 MR. HUME: All right, thank you.

22 MR. WHITE: With suggestions as to
23 which agency of Government might be expected to
24 establish these standards.

25 THE CHAIRMAN: Mr. White, without trying
26 to prolong this, but to join some questions that I
27 have in my mind, I wonder if you would go back on
28 another point, to the top of Page 53. Would you be
29 good enough to pursue the last sentence of the first
30



1 paragraph?

2 MR. WHITE: Very good. I had a little
3 notation there too.

4 THE CHAIRMAN: Who are those people?

5 MR. WHITE: Yes. Mr. Conder the last sentence
6 in that paragraph, top of Page 53 says: "I was
7 advised that invoices were found on the
8 premises which indicated sales to Canadian
9 importers."

10 Could you tell the Committee the names of
11 those Canadian importers?

12 MR. CONDER: I don't have the names with
13 me, Mr. White.

14 MR. WHITE: Where would we be able to find
15 the names of those importers?

16 MR. CONDER: One of two ways. I would
17 presume that the Food and Drug Directorate in Ottawa
18 may have them. In view of the legal implication
19 in this case in the United States, it might be
20 conceivable that the Attorney General of the State
21 of New Jersey would be prepared to supply them for
22 this Committee.

23 THE CHAIRMAN: Do you have them Mr. Conder?

24 MR. CONDER: No, I do not.

25 MR. HUME: You said you did not have them
26 with you. You implied you may have them somewhere.

27 MR. CONDER: I do not have them at the
28 office.

29 THE CHAIRMAN: Could you acquire them?
30



1 MR.CONDER: I will certainly attempt to
2 get them for you.

3 THE CHAIRMAN: I think that would be proper.
4 This Committee has no obligation or is not subservient
5 to any other jurisdiction in any other country.

6 MR. CONDER: I have with me a brief file
7 on this particular matter. If it would be of interest
8 to the Committee, I would be glad to leave it with
9 the Committee.

10 THE CHAIRMAN: I think that it is a rather
11 important point and one of the useful purposes of
12 the Committee would be to see that that information
13 is disclosed to the public.

14 MR. HUME: Mr. Chairman we would be delighted
15 to write and attempt to get it. In the event that
16 there is some reluctance to give it, this Association
17 has no right to demand it. The Committee, I suggest,
18 probably has and if we run into difficulty, we will
19 advise the secretary.

20 THE CHAIRMAN: We do not wish to impose
21 an undue burden on you.

22 MR. HUME: We will try.

23 THE CHAIRMAN: If you would try, and if
24 you run into difficulty, please let us know.

25 MR. HUME: We certainly will.

26 MR. WHITE: At the tope of Page 57, the first
27 sentence says: "The brand-name manufacturer

28 which stands behind its products will take
29 back for credit from drug stores and hospitals,
30



1 drugs which have passed their expiry period
2 and so lost their effectiveness."

3 The first question is: will they take back for
4 credit from Departments of Government?

5 MR. CONDER: Yes.

6 MR. WHITE: The second questions is: is
7 this always the policy or are just some drugs taken
8 back and not other ones taken back?

9 MR. CONDER: To the best of my knowledge
10 this would be the policy of all major companies in
11 respect to products which have passed their expiry
12 period and so lost their effectiveness.

13 MR. WHITE: Is it fair to say then that
14 drugs supplied to any source whatsoever by the
15 members of your Association are always taken back for
16 full credit, and that there is, therefore, no obsolescence
17 involved?

18 THE CHAIRMAN: That is, on the part of
19 the consumer?

20 MR. WHITE: On the part of the distributor.

21 MR. CONDER: To the best of my knowledge, that
22 is the case.

23 THE CHAIRMAN: Mr. White, it seems to me
24 then that it is only fair that if that is the case
25 then there must be a dollar value which must be
26 absorbed by the companies.

27 I wonder what the extent of that dollar
28 value is because that is an absolute write-off.
29 This is more than a cost factor. There will be freight
30



1 charges and a return credit figure. It may involve
2 more than just the invoice price, and in fairness
3 I wonder if that information should not be made
4 available. Once again, we are talking about individual
5 companies but as it has been pointed out, this is your
6 brief.
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2 MR. BOYER: Mr. Chairman, might
3 I ask if such drugs have to be scrapped entirely,
4 or if there is any recovery value that comes from
5 them? Is that correct? All of his drugs that are
6 taken back, do they come under your scrapped item?

7 MR. CONDER: I believe that is the case.
8 drugs that are returned, are destroyed, I know of no
9 case where they might be used in any form again.

10 MR. WHITE: I asked if they were taken
11 back for full credit? Actually your brief does not
12 say that they are taken back for full credit or
13 90%, or what portion.

14 MR. CONDER: This would depend on the
15 company's policy in that respect, and it would have
16 to be answered according to the specific company's
17 policy.

18 MR. WHITE: What has been your experience
19 is it full credit or part credit?

20 MR. CONDER: To the best of my knowledge,
21 depending on what the particular products will be,
22 it will be the full credit to the person that paid.

23 MR. WHITE: On page 61 at the top of the
24 page reference is made to the chart on the opposite
25 page and it says, "From a standpoint of averages,
26 the chart indicates that these 14 companies each
27 compared an average of 86 products."

28 May I ask if those 14 companies submitted
29 a full list of all of their products, or if they were
30 permitted to produce what they might allege were a



1 representative portion of their products?

2
3 MR. CONDER: Our question to them was
4 this: I would ask them to supply a comparison of
5 products which were sold in the United States as
6 against those sold in Canada. It is conceivable,
7 of course, that some companies in here might
8 possibly sell products in the United States, but
9 they do not sell them in Canada and vice versa.

10 MR. WHITE: I submit Mr. Chairman that
11 chart is meaningless. A, because there were very few
12 companies submitting information, and B, because
13 the companies which did submit the information had
14 free choice of what drugs they would refer to and
15 might, if they wished, have shown a favourable
16 comparison.

17 MR. CHAIRMAN: I would think that
18 that list of 86 products should be filed in confidence
19 with the secretary.

20 May I interrupt you for a moment, Mr.
21 White, because I think this might be an opportune
22 time for me to make any observation which I think
23 is pertinent to this Committee's hearing.

24 We are faced with companies doing
25 business in Canada and with which this Committee
26 is concerned who are controlled or owned by foreign
27 companies, some of them on this continent and some
28 on other continents.

29 I am trying to be discreet in my
30 language. I know of my own knowledge that the most



1 unfortunate situation exists, Mr. White, with
2 respect to so-called Governmental investigations
3 in other countries, not necessarily regarding drugs,
4 but having to do with customs, tariff matters,
5 pricing and so on which has created a situation in
6 those countries which has caused many people
7 connected with those industries to live almost in
8 a state of fear.

9 I have experienced this in my own
10 practice of law having to do with the mental climate,
11 shall we say, of companies who are called upon to
12 supply information or answer questions posed or
13 asked by so called governmental bodies or authorities.

14 In the spirit in which we in this
15 Committee-- and I join all of us in this statement --
16 have endeavored to conduct the hearings of this
17 Committee, I would hope that that fear complex
18 might be allayed at once, and as far as I am
19 concerned personally, for ever, because the good
20 faith of this Committee I think I can say to this
21 moment, has not been breached in spirit deliberately
22 by any member of this Committee.

23 This is not a prosecution Committee
24 and as I have said many times, no one is charged
25 with anything.

26 The question that you raised, Mr. White
27 led me to recall this observation and I felt I
28 should make it because companies coming before this
29 Committee or parties or anyone should and may feel
30



1
2 free to come here with perfect protection that
3 they will receive a courteous hearing and not
4 be subjected to personal abuse. I make this
5 statement that I am sure that what I am saying will
6 strike a note with some of you who are present.

7 What I am saying I am sure -- would
8 everyone agree with me -- reflects the spirit and
9 intention of the members of this Committee. I
10 thought this a very important point to make because
11 of some of the observations I have heard. Is that
12 a fair statement in connection with your question,
13 Mr. White?

14 MR. WHITE: I think it is a fair
15 question and a fair statement and in view of
16 that statement I will withdraw my remarks that the
17 chart on page 60 is meaningless and ask the witness
18 if he thinks this chart has any validity having in
19 mind the very small returns on the average and that the
20 manufacturers submitting the information were able
21 to pick and choose the drugs prepared. Has it any
22 validity in your opinion as an expert, Mr. Conder?

23 MR. CONDER: In my opinion this chart
24 does have validity and that the companies did a fair
25 and honest job of selecting this information.

26 MR. WHITE: On page 63, Mr. Chairman,
27 I would hope that we could establish the cost of
28 promotion as a percentage of sales and as an absolute
29 dollar figure. Referring to the third paragraph:

30 "For this reason the pharmaceutical



1 companies use three principal means
2 of informing the doctor about new
3 products, and improvements in old
4 ones."

5 Where is the exhibit of advertising
6 costs? What page is that, Mr. Conder?

7 MR. HUME: You mean the one on page
8 65, the number of mailings, or the one on page 66?

9 MR. WHITE: Yes, the Association has
10 prepared this brief and has informed the Committee
11 that advertising constitutes about 6 and one half
12 percent of their sales volume.

13 I would ask through you, Mr. Chairman,
14 if the Association would also establish the relation
15 of the manufacturer's sales dollar for professional
16 service representatives or detail men and for medical
17 journal advertising?

18 Excuse me, I will correct that, if they
19 would establish the cost for professional service
20 representatives or detail men in the same way they
21 have established the cost for direct mail and journal
22 advertising.

23 THE CHAIRMAN: Should you define that
24 a little further, Mr. White? I mean, what is a
25 detail man's expense? Is it the salary or his
26 commission or does it include travelling expenses,
27 car allowance and so on, or I wonder if we should
28 distinguish just exactly what you want.

29 Let me put it this way, I think we should
30



1
2 define it more closely.

3 MR. WHITE: Might I ask, first of all,
4 are some or most detail men paid a commission on
5 sales in their territory?

6 MR. CONDER: It varies according to the
7 company. Some are on straight salary and some are
8 on salary with some form of commission, Some are
9 on salary against direct allowance. It depends
10 upon the particular company and its policies.

11 MR. WHITE: You or one of the other
12 witnesses told us detail men were not salesmen.
13 You now inform us that some detail men are paid a
14 commission on their sales.

15 MR. CONDER: It depends on the company
16 and the products of that company in that respect.

17 MR. WHITE: But some of them are.

18 MR. CONDER: Some of them are, that
19 is correct.

20 MR. HUME: May I give what I hope
21 would be a solution. It is not simple to go through
22 the transcript and pick out these questions. It
23 seems to me that these are important matters --
24 and I am sure they are -- that Mr. White and other
25 members want to know about. If during the recess
26 when we adjourn today or tomorrow, if they would
27 state again, if the secretary and the counsel of the
28 Committee could draft a questionnaire setting out
29 the questions upon which you would like the
30 Association to submit to members for answer, it



1 would be perhaps more satisfactory than for us
2 to go through the transcript picking out these
3 things. There have been three days of it. It
4 is not designed to put an undue burden on the members
5 by making a list of questions that we have to answer,
6 but we can do the rest of the work, sending it
7 out, getting replies and sending them back to the
8 Committee. It seems to me better than having us
9 formulate the question because it might not specify /
10 the requirements.

11 MR. WHITE: That is a very good suggestion.

12 THE CHAIRMAN: Yes, it is a good
13 suggestion but I do not think it means it should
14 take away from the Committee the right to ask
15 questions.

16 MR. HUME: Oh no, of course not but
17 Mr. White asked a definite question and said, "will
18 you get so and so?" He is going on to something else
19 and it occurred to me that he has asked us to
20 obtain this information and if this could be put
21 in a questionnaire plus any other questions which
22 would occur to anybody, we would be glad to do the
23 campaign job of sending out the questionnaire,
24 getting back the replies, putting pressure on the
25 delinquents, and turning the answers over to the
26 Committee.

27 THE CHAIRMAN: As a matter of fact this
28 should be a co-operative effort between the Committee
29
30



1 and your members, shouldn't it?

2
3 MR. HUME: Yes sir.

4 MR. WHITE: Mr. Chairman, that is
5 about half of my questions. It has taken a little
6 longer than I hoped it would. I will proceed if
7 you wish.

8 THE CHAIRMAN: I think we should
9 adjourn for lunch.

10 MR. GADSBY: Information has come to
11 hand since yesterday that certain of the companies
12 from the Canadian Pharmaceutical Association would
13 like to appear on their own behalf. One name I have
14 at the moment is Burrough's Welcome Company.

15 THE CHAIRMAN: Mr. Hume, have you any-
16 thing?

17 MR. CONDER: Could you amend that please,
18 the Canadian Pharmaceutical Manufacturers Association?

19 MR. GADSBY: What should I say?

20 MR. CONDER: The Canadian Pharmaceutical
21 Association represents retail pharmacists.

22 MR. HUME: Perhaps this is a good
23 chance to say a few words. I am not going to delay
24 it because I know it is late, but following the
25 discussions which are very clear in my memory from
26 yesterday afternoon, it was the intention of this
27 Association's brief to present the Association
28 picture, and I think we have done so. Some things
29 have been said about us and we appreciate it.

30 As a result of the discussion yesterday



1 afternoon, I have a very short time available to me
2 and I did not have any brief for any individual
3 company. I took it upon myself to consult counsel
4 and others to see what information I should give
5 this Committee as to individual members coming
6 forward.
7

8 Some of these companies have pointed
9 out quite properly and I am sure from what you just
10 said a few minutes ago that any information they may
11 give is confidential if they do not want their
12 competitors to know, and they have no objection
13 to supplying the Committee with information, but
14 they do not want to make it public.

15 Notwithstanding that I am very happy
16 to say that two of the member companies of the
17 Association have advised me, namely, Burroughs
18 Welcome Company and Ayerst McKenna Limited that they
19 will be very pleased to discuss with your counsel
20 the area in which you may be interested to have their
21 evidence.
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1 When you resume in the spring after reconstitution,
2 they will be delighted to make submissions and you
3 have the assurance that these two companies will
4 in fact be coming forward and others, I am sure, will
5 see fit...

6 THE CHAIRMAN: I think that is a very
7 happy development. We will adjourn until 2:15.

8 ---Luncheon adjournment.

9
10 THE CHAIRMAN: Gentlemen, in resuming,
11 Mr. Conder is still with us and there are some other
12 questions now. Mr. Kelly...?

13 MR. KELLY: Mr. Chairman, I represent the
14 E. R. Squibb & Sons (Canada) Limited and I am instructed
15 that the company which I represent was prepared
16 to make available to the Committee any information
17 which would be helpful to the Committee's investigations;
18 subject, of course, to natural reservations in regard
19 to disclosure of information which is of value
20 to our competitors, but not to the Committee.

21 I hope that we will be able to arrange
22 through you or Counsel and have some indication in
23 the areas in which this information is required and
24 how to bring representatives of the companies here
25 without knowing beforehand what is to be said.

26 THE CHAIRMAN: Thank you.

27 MR. HUME: Mr. Chairman, I would like to
28 add two things to what I mentioned before lunch.
29 I am now instructed to advise the Committee that the
30



1 Charles E. Frosst and Company have added their names
2 to the ones I mentioned before lunch as ones which
3 will be coming forward.
4

5 THE CHAIRMAN: That will be very helpful,
6 gentlemen, and we appreciate the co-operation.

7 Now, we were before the recess in the
8 midst of some examination by Mr. White. Mr. White...

9 MR. WHITE: Thank you.

10 THE CHAIRMAN: How long do you think it
11 might take? Is that a fair question?

12 MR. WHITE: I would think fifteen or twenty
13 minutes.

14 On Page 66, it is shown that the average
15 expenditure for the 33 companies reported that
16 their average expenditure was six and a half per
17 cent of their total sales volume. You have compared
18 certain expenditures to the C. M. A. averages.
19 Can you compare that six and a half per cent to
20 the C. M. A. average?

21 MR. CONDER: I don't believe that the
22 Canadian Manufacturers' Association breaks that
23 down in their survey, Mr. White.

24 MR. WHITE: Reference is made to compulsory
25 patents. We were given some information on it by
26 the head of the Department in Ottawa. He described
27 to this Committee the procedure whereby a firm can
28 apply for licensing privileges under some other
29 manufacturer's patent. He states further that
30 14 applications have been made to his Department since



1 the compulsory patent legislation was passed, five
2 of which have been approved. Can you tell me if
3 any of your members applied for compulsory patent,
4 so-called?

5 MR. CONDER: Unfortunately, I have no
6 exact facts on that at all.

7 MR. WHITE: Compulsory licence...?

8 MR. CONDER: Yes.

9 MR. WHITE: Can you tell me if any of
10 your members owned patents against which application
11 was made/ other non-member companies?

12 MR. CONDER: I believe so.

13 MR. WHITE: Do you know how many of the
14 applications were concerned with patents owned
15 by your members?

16 MR. CONDER: No. I have no idea of that.

17 MR. WHITE: Can you tell us how many of
18 these five that were approved were against your
19 members?

20 MR. CONDER: No.

21 MR. WHITE: Is there a by-law in your
22 Association or is there a gentlemen's agreement that
23 one of your members will not seek compulsory licence
24 against another of your members?

25 MR. CONDER: There is no by-law to that
26 effect, nor any regulation.

27 MR. WHITE: We were told by Dr. Ferguson,
28 the head of the Connaught Laboratories, that he
29 felt the compulsory provisions, while they seem to
30



1 open up the field to some extent, to the free play
2 of competitive forces, he thought in actual practise
3 it was not very meaningful, unlike your advisor,
4 Mr. Dixon. Would you care to comment?

5 MR. WHITE: It would depend primarily on
6 the area in which you are interested in -- meaningful.
7 I would venture that the end price of the product
8 would not be affected measurably by royalties,
9 for example, as I believe was pointed by Dr. Ferguson
10 at the time. But, aside from that, I am afraid I
11 could not go much further.

12 THE CHAIRMAN: May I ask, Mr. White,
13 without interrupting you -- Have you any knowledge,
14 Mr. Conder, of the basis of royalties, with respect
15 to drugs? Is it by the pill, by the bottle, by
16 the hundred, by the content, or...?

17 MR. CONDER: No. We have no knowledge
18 whatever of that aspect of it.

19 THE CHAIRMAN: Do you as an individual have
20 any general knowledge of it?

21 MR. CONDER: I have not.

22 MR. WHITE: As an expert in the field,
23 can you tell me and the Committee what discount is
24 usually granted by drug manufacturers to retailers?

25 MR. CONDER: This depends on the type of
26 operation of the company, its method of operation,
27 whether it deals direct through depots or through
28 wholesalers and other things. I would suggest that
29 this type of information might be better coming from
30



1 the individual companies concerned.

2 MR. WHITE: Well, I can't accept that
3 answer, Mr. Chairman. We were told very candidly,
4 without any reservation, by Dr. Ferguson, that the
5 practise is 40 per cent. We were given similar infor-
6 mation by Professor Fuller from the University of
7 Toronto. We were given similar information by the
8 Manager of the Pharmaceutical Association and, I
9 suggest, Mr. Chairman, that this gentleman must
10 know what the convention is in the industry.

11 THE CHAIRMAN: Yes. I think I should
12 probably put it to you this way, Mr. White -- that
13 I gather -- If I am wrong, Mr. Conder, will you
14 correct me. But, I gather that in Mr. Conder's
15 position as General Manager of this Association,
16 in his official capacity he has no knowledge nor
17 information on that subject. It might be that as an
18 individual and in his experience with the drug trade
19 generally that he might be able to comment in a
20 general way on the point.

21 MR. WHITE: Yes. That is why I said as
22 an expert in the field. I am not asking him to
23 answer that question as manager of the Association,
24 but he is a proven expert in the field of drugs
25 and I ask him as an expert, as not as the Manager
26 of the Association.

27 MR. CONDER: I just may say this, Mr.
28 White, that we have kept away completely at the
29 Association level and...
30



1 THE CHAIRMAN: Mr. Conder, let us not go
2 into that. Mr. White is making a very good point.
3 He is asking you as an individual, as an experienced
4 man who has been exposed to the operations of many
5 drug companies, what the practise is in the business.
6 Now, that is the question.

7 MR. WHITE: Yes.

8 THE CHAIRMAN: What is the practise? Do
9 you know or don't you?

10 MR. CONDER: All I can say is that in some
11 cases, some companies have the 40 per cent which
12 you refer to but in other cases there are wholesale
13 discounts which enter into it and I am not qualified
14 as an individual to go into that aspect of it.

15 THE CHAIRMAN: Let us take this one step
16 at a time. First, the general practise in the trade.
17 Do you have any knowledge of that?

18 MR. CONDER: No. I have no knowledge
19 whatever of that.

20 THE CHAIRMAN: I would have to agree with
21 Mr. White that I think it is an unsatisfactory answer.

22 MR. WHITE: Mr. Chairman, my questioning
23 of this witness is almost complete and I would not
24 ask that this step be done now, but when witnesses
25 appear before, or in future, I think we should have
26 them sworn, as is our privilege. If we do not
27 have all of them sworn, if we single out certain
28 individuals or companies to be sworn, then, of course,
29 it will cast a reflection on that company or person.
30



1 But, I would like to see witnesses before this
2 Committee sworn in future and then, if we should
3 run into what we think is evasion, or something of
4 that sort, the Committee has power to take some
5 action.

6 I am going to pass that question, Mr.
7 Chairman and similar questions relating to prices
8 to hospitals and governments and other distributing
9 channels, because I feel that the answer won't be
10 any more satisfactory than the previous one.

11 If I am mistaken in that, Mr. Conder,
12 tell me and I will detail my questions concerning
13 prices to these other destinations.

14 THE CHAIRMAN: By the way, while we are at
15 this point, it might be well to point out that
16 with reference to our remarks yesterday, we did not
17 wish to impose an unfair burden on Mr. Conder, but
18 the fact is that you are the general manager of
19 the Association and you and Professor Dixon and
20 Mr. Hume are the three men your Association has
21 put up to support this brief as experienced men
22 in the field.

23 Now, it may be that Mr. Hume knows the answer.
24 Do you have the answer? Do you know what the
25 practise is?

26 MR. HUME: No. I have absolutely no informa-
27 tion about prices. In addition to that, I have
28 advised this Association that Mr. Conder is not to
29 have anything in his records dealing with prices,
30



1 discount or anything else. Now, he may know in
2 his personal capacity. I know that it has been
3 40 per cent because I have been reading the transcript,
4 but I am afraid that I have no information.

5 THE CHAIRMAN: I think it is a reasonable
6 question to put and there is a very important
7 principle involved here with respect to the presentation
8 of these briefs. I made the point yesterday and
9 I have the greatest regard and I am sure the other
10 members of the Committee do for Mr. Conder personally
11 and professionally, but I will repeat that I think
12 you are being placed in a most unenviable position.

13 MR. CONDER: It might appear, Mr. White,
14 evasive, but I can assure you, sir, that it is
15 not. I know that from here, as Mr. Hume said, the
16 reference to 40 per cent. I do know there is
17 in some cases wholesale discount and other factors
18 coming in, but I just honestly don't know.

19 THE CHAIRMAN: We will have to accept
20 that for the moment.

21 MR. WHITE: In the supporting brief offered
22 by Mr. Dixon, he breaks down sales on Page 25 into
23 several broad drug classifications. One is
24 pharmaceutical and biologicals. I guess that is
25 correct, isn't it, Mr. Conder?

26 MR. CONDER: Yes.

27 MR. WHITE: Pharmaceuticals?

28 MR. CONDER: Yes. That is correct.

29 MR. WHITE: Pharmaceuticals and biologicals.
30



1 The second is penicillin and preparations, and the
2 third is other antibiotics. Now, the association
3 has given us in your brief, Mr. Conder, the alleged
4 margins of profit as a percentage on sales and
5 information enabling us to find the margin of profit
6 as a percentage of net worth for total in these
7 industrial sales. Would it be possible to determine
8 the profit as a percentage of sales and as a percentage
9 of net worth by those three categories?
10

11 That, Mr. Chairman, is another subject
12 that I would like to suggest for the survey that
13 will be sent to the Association, with the help of
14 our consultants, for this reason it may be on certain
15 preparations which are manufactured by many drug
16 companies in Canada and elsewhere that the margin
17 of profit is very small.
18
19
20

21 (Page 1434 follows)
22
23
24
25
26
27
28
29
30



1
2 It may be that in another category, because of patents,
3 because of licensing provisions, because of branding
4 of drugs or for some other reasons, that the profits
5 are very large. I don't think Mr. Conder can give
6 us any evidence on that point. If you can, I would
7 ask you to do so.

8 MR. CONDER: No, it has not been done
9 at any time to my knowledge.

10 MR. WHITE: Then I would ask that our
11 consultants take that into consideration in preparing
12 a new survey.

13 MR. HUME: I suggest, Mr. White, that to cal-
14 culate the percentage related to net worth would have to
15 be calculated in cases of these companies that manufacture
16 more than one list of products. In other words, their
17 plant would have to be divided between the various
18 products in order to determine the net worth of the plant
19 related to that product. This would have to be adjusted.

20 MR. WHITE: That is the only way.
21 At page 38, Mr. Chairman, three-quarters of the way
22 down the page, this is Mr. Dixon's report, Mr. Dixon
23 has said:

24 "Assuming an industry markup from manufacturer
25 to consumer price of about 40% on retail,
26 and assuming a drop in profit as a percen-
27 tage of the sales dollar from the average
28 actual performance of 6.3% to the all
29 manufacturing average of 3.8%, this change
30 would result on each dollar of retail selling
price in a reduction of 1.35% at the retail



1
2 level, even provided that everything else
3 remained equal."

4 MR. HUME: That was corrected, Mr. White.
5 1.5.

6 MR. WHITE: Oh, I beg your pardon. I
7 wasn't here when the correction was made. I was away.

8 THE CHAIRMAN: 1.35 became 1.5.

9 MR. WHITE: 3.5?

10 MR. HUME: It is corrected. My note
11 says 1.5.

12 THE CHAIRMAN: So that in the sixth
13 line from the bottom on page 38, the line should read
14 "selling price in a reduction of 1.5%".

15 MR. HUME: Yes.

16 THE CHAIRMAN: "at the retail level, even
17 provided". Is that your understanding?

18 MR. HUME: Yes.

19 MR. WHITE: I think, Mr. Chairman, that
20 should be 2.5. It is not very important, perhaps,
21 but I think it is a mistake for the reason that any
22 decrease in the wholesale price would be further
23 decreased at the retail level having in mind that the
24 retailers' price is set on a percentage basis.
25 However, I don't think it wants a long discussion.

26 MR. HUME: You may be right and I think
27 it is worth while checking up with Doctor Dixon to
28 find out for sure, and we will let you know.

29 THE CHAIRMAN: Mr. Secretary, when you
30 get the transcript tomorrow, would you refer to page



1
2 38 of Professor Dixon's brief and Mr. White's remarks
3 in the transcript and write Doctor Dixon and ask his
4 comment.

5 MR. WHITE: That is all I have.

6 THE CHAIRMAN: Are there any questions
7 from any other interested party to this hearing of
8 the witness? Well then, Mr. Conder, thank you very
9 much for coming before us, and we appreciate the
10 onerous nature of your testimony in being here, and
11 we do thank you for your cooperation.

12 MR. CONDER: Thank you, sir.

13 THE CHAIRMAN: Thank you, Mr. Hume.

14 MR. HUME: Thank you, Mr. Chairman.

15 THE CHAIRMAN: The next brief is ----

16 MR. WHITE: Excuse me for interrupting.
17 Before the next witness is called may I ask for your
18 ruling on my request that witnesses be sworn?

19 MR. CHAIRMAN: Yes. In the same manner
20 in which I have spoken about the conduct and nature
21 of these hearings and subpoenaing witnesses, speaking
22 personally, it has always been my hope that we would
23 be able to accomplish the proceedings without that
24 necessity. We assume that these hearings are being
25 conducted in good faith.

26 However, should it appear that they are
27 not or that there is any deliberate evasion or wrong
28 testimony, then, of course, that would call for the
29 swearing of a witness.

30 Now, I am only one member of the Committee



1
2 and I would be and shall be governed by what the
3 Committee members say. However, it is normal practice
4 in hearings of this type, and I shall try to speak
5 and set an example for the kind of testimony that I
6 hope some other witnesses might have given; it is
7 my own experience that in hearings before the Board
8 of Transport Commissioners, Tariff Board and other
9 bodies including Royal Commissions, that the witnesses
10 are not sworn unless there is some specific reason
11 for it.

12 I have known in the last two or three
13 years with respect to Ontario Government Committees
14 that there have been occasions when witnesses have
15 been sworn. There has been a specific reason for it.

16 MR. WHITE: I will withdraw the request.

17 THE CHAIRMAN: I am only speaking as
18 an individual, Mr. White, and of course would be
19 governed by what the Committee says.

20 MR. WHITE: I would like to withdraw
21 the request, Mr. Chairman, for further consideration.

22 THE CHAIRMAN: I would think that is a
23 very desirable thing at this moment. I think it
24 would be unfair at this stage of the hearing, for
25 instance, right now, and let's be specific, to swear
26 Mr. Gilbert. I think that would be unfair. If we
27 decided on a change of policy, then I think it should
28 be effective for the next set of hearings.

29 MR. WHITE: Yes.

30 THE CHAIRMAN: The next brief will be



1
2 from Jules R. Gilbert Limited. Mr. Gilbert.

3 --- Jules R. Gilbert, called

4
5 THE CHAIRMAN: Were you here the other
6 day, Mr. Gilbert, when we discussed the reading in of
7 tables?

8 MR. GILBERT: No, I was not.

9 THE CHAIRMAN: The reporter will take
10 into account details of tables automatically, and they
11 are a rather laborious chore sometimes to read them
12 in in columnar form, et cetera. I would suggest to
13 facilitate our proceedings that you might not read
14 them all in. But it is your choice if you wish.
15 If you accepted my suggestion, it would still remain
16 for you to stop at a table and discuss any pertinent
17 aspects or points contained in it.

18 MR. GILBERT: I myself would appreciate
19 not having to read the tables, but I would like an
20 opportunity to comment on them.

21 THE CHAIRMAN: Yes.

22 MR. GILBERT: In the beginning, I would
23 like to say so far as I am concerned I consider myself
24 under oath in anything I say.

25 Mr. Chairman - members of the committee:
26 I am pleased indeed to appear before this august body
27 in an endeavor to assist you in your deliberations if
28 I can, and possibly point out the road towards the
29 solution of at least part of your problems.
30



Motives of Experts

The investigations of the high cost of drugs has resulted in many conflicting statements both in the press and among the experts called to testify. If any truth or realism is to be arrived at - it becomes important to examine the motives of each testifying expert.

Motives of Gilbert & Company

As the only vocal generic drug manufacturer in Canada, and because of my frequent contacts with pharmacists, medical profession, hospital administrators, hospital service plans, governmental purchasing agencies, I have had opportunities to observe the paradoxes existing in the selling of drugs. My intimate knowledge with the manufacture - chemical control and research in drugs permit me to evaluate these elements. To allow me to be truthful in my testimony, I come before you and say - my motive is to sell drugs at the best possible profit. Anything I say must then be viewed with the suspicion that my statements are designed to yield my company a greater profit. It so happens that my best interests are served by telling the unvarnished truth, and to divulge facts that others in the industry would prefer not to be known.

(Page 1444 follows)



1
2 I am vocal because I consider it good business -
3 the fact that Canada as a nation may benefit
4 economically by what I am doing or that some
5 people's lives may be saved, because they now can
6 afford more and better drugs, is a happy by-product
7 for my company, and does give me some compensating perso-
8 nal satisfaction. To pretend, that this was my primary
9 objective would be to brand myself a liar.

10 When there are so many falsehoods abounding and
11 economic empires built by the power of money to
12 hypnotize - to me - it seemed that the only way
13 to get in was by sticking to stark facts and having
14 the courage of my convictions. I only want a small
15 portion of this Bonanza, and hence I stood before you
16 today.

17
18 Of the presentations of Dean Hughes of the College
19 of Pharmacy, Mr. Martin of the Ontario Hospital
20 Association and Dr. McDonald, Dr. McDonald was the
21 only one who did not seem to have an axe to grind
22 and was not attempting to create a picture by
23 allusion.

24
25 The following factors and groups have a bearing on
26 the cost of drugs. They are arranged in the order of
27 effect and importance:

- 28 1. The Patent law and its interpretation.
- 29 2. The Canadian Pharmaceutical Manufact-
30 urer's Association.



1 For High 3. Policy directing officers of the
2 Cost of various Pharmaceutical Associations.
3 Drugs. 4. The College of Pharmacy.

5. The indoctrinated doctors.

6 Caught in the millstream of the above:

7 6. The Hospital Pharmacist

8 7. The Neighbourhood Druggist.

9 The Factors combatting the above are:

10 8. The right thinking druggist.

11 9. The scientific doctor.

12 10. Governmental Purchasing Agencies.

13 11. Generic drug manufacturers.

14 12. Consumer Organizations.

15 13. The Public.

16 14. The Combines Investigation.

17 At this point my experience will be highlighted in
18 order to present a background of authority for my
19 statements. I might skip this if you would care to
20 save the time. I imagine it is in the record.

21 THE CHAIRMAN: I think you should put
22 it in the record.

23 MR. GILBERT: Thank you.

24 Age 53 -- Married -- Two daughters.

25 1926 Graduated from Columbia College
26 of Pharmacy - Ph.G.

27 1926- Two years two summers with G.W.
28 Carwick Co., Newark, N.J. -Laboratory
29 Control and Research in endocrine
30 products.



1
2 1931 - B. S. in Ch. Engineering - Cooper
3 Union Institute of Technology.

4 1932 - Research Chemist in privately
5 endowed Cancer Research.

6 1933 - Assistant Supervisor pharmaceutical
7 Department National Aniline and Chemical
8 Company, Buffalo, N. Y. Synthesized
9 about 200 Organic and Biological stains.

10 1936 - Started National Synthetics Inc.,
11 - now - Bell-Craig Inc., - New York
12 City - manufacture of X-Ray diagnostic
13 media.

14 1945 - Patent Action: Schering versus
15 Gilbert decided.

16 1946 - Started drug company in Toronto -
17 producing a variety of drug specialties -
18 no longer associated.

19 1948 - Gilbert Surgical Supply Company
20 Limited, - Hospital Supplies.

21 1953 - Jules R. Gilbert Ltd. as drug
22 jobber.

23 1957 - Gilbert & Company embarked on
24 Generic Drug Program.

25 GILBERT & COMPANY JULES R. GILBERT LTD.

26
27 Gilbert Surgical Supply Co. Ltd. does business as
28 Gilbert & Company engaged mainly in sales to doctors,
29 hospitals and drug stores. We currently occupy a
30 20,000 ft. single story building devoted to 4000 ft.



1 office space, 9000 ft. warehouse and 7000 ft. of
2 packaging manufacturing and laboratory area. The
3 manufacturing area has excellent equipment for
4 manufacture of tablets, capsules, powders and liquids.
5 The production efforts are almost completely dedicated
6 to our own products. We do not seek custom manufact-
7 uring. The Laboratory is used to perform in process
8 controls. All raw materials and finished products are
9 tested by an independent Laboratory on a retainer
10 basis.
11

12 The companies are faced with ten patent suits
13 entered by Parke-Davis, Poulenc, Pfizer, Schering
14 Horner, Haechst, American Cyanmide, G. D. Searle
15 and Ciba. The Frosst action was voluntarily withdrawn.
16 We are countersuing two companies - Horner and Frosst
17 under the Ontario Monopolies Act.
18

19 I might add at this point that we are also suing
20 the Canadian Pharmaceutical Association and
21 Mr. Conder for libel.

22 Further expansion plans are in progress to provide
23 a model control and research laborator and a sterile
24 area for packaging antibiotics.

25 The Pharmaceutical plant is staffed by capable
26 experienced personnel.

27 I would like to suggest at this point that if any
28 of the members care to interrupt me at any part of
29 the proceeding I wouldn't mind it.
30



1 THE CHAIRMAN: No. I think it presents
2 a more orderly presentation if you proceed through
3 your brief first.

4 MR. GILBERT: Thank you.

5
6 THE CANADIAN PATENT LAW

7 Effect of the Patent law

8 This is the crux of the problem.

9 By means of the Patent Law Foreign Companies have
10 been legally enabled to arrogate unto themselves rights
11 and monopolies which set the pattern for the drug
12 industry.

13 This statement does not infer that the Canadian
14 Patent Law is a bad law. To the contrary the law was
15 framed in such a way as to protect the public against
16 monopolistic practices, and to promote a native
17 Canadian Drug Manufacturing Industry.

18 Because my companies are now being faced with ten
19 separate Patent suits. I am in no position to discuss
20 the merits of each action, since I am advised that
21 this would be sub judice.

22
23 Section 41 of the Patent Act which deals with Food
24 and Medicine spells out the protections to the
25 public. To exercise the protection spelled out in
26 the act, has already cost our company tens of
27 thousands of dollars and many more tens of
28 thousands of dollars will be attained.

29 SECTION 41 OF PATENT ACT RELATING TO DRUGS AND MEDICINES

30 In this last sentence lies the essence or the magic



1
2 touchstone which has permitted the Brand Name Drug
3 Industry to defy all laws of economics.

4 Since one Patent Suit against us was withdrawn by
5 one of the companies, I can feel free to discuss this.
6 A writ was drawn against my company, and an applic-
7 ation for injunction was presented to the Exchequer
8 Court in Ottawa, accusing us of infringing their
9 product.

10 We made several efforts by presentation of samples to
11 convince the company that we were not infringing their
12 patent. We were told that regardless of the samples
13 they were going to sue anyway. They maintained this
14 position until the day before the scheduled hearing.
15 On the last day the case was adjourned "sine die"
16 and some months later the action was withdrawn.

17 STATUS OF PATENT SUITS

18
19 To some measure this pattern is being employed in all
20 our patent suits. Parke-Davis has adjourned two trial
21 dates "sine-die". Pfizer has just succeeded in
22 obtaining their 4th or 5th adjournment.

23 It is of interest to note that to this date in
24 Canada there has not been a single adjudication of
25 a drug patent in Canada as between companies.

26 ELABORATION OF GRANTING OF PATENTS

27 By extrapolation of various decisions by the patent
28 Office, the patent attorneys have been continually
29 expanding and widening their ability to obtain
30 patent coverage. The principle being that the members



1
2 of the Club must of necessity protect their gains.
3 The non-patent holders on the other hand would not
4 have the audacity to defend themselves against an
5 infringement action. If pressed I could illustrate
6 several incongruous actions which exist in our own
7 files. The holder of a patent is enjoying a full
8 monopoly on a one-way street. He enjoys the right
9 to protect himself for 17 years - but should he
10 be proven wrong he will never have to pay back his
11 ill-gotten gains.

12 To-day the validity of this principle is being
13 tested by two counter actions under the Ontario
14 Monopolies Act. My companies feel (a) that a patent
15 should be properly obtained within the meaning
16 of the act - and - (b) that it should not be used
17 as a club beyond the powers spelled out in the act.

18 THE CHAIRMAN: I don't wish to interrupt
19 you but you will appreciate that we have no control
20 over Patent Law, which is a matter of Federal
21 jurisdiction, and in any investigation which this
22 Committee conducts we must necessarily take the
23 law, over which we have no control as it is.

24 MR. GILBERT: I am not asking the
25 Committee to do anything about it. I only bring
26 this out from the point of view that these are the
27 things that affect the cost of drugs. I am not trying
28 to try the Patent Law here.

29 THE CHAIRMAN: That is a fair explanation.

30 MR. GILBERT: Thank you.



1
2 SPHERES OF INFLUENCE

3 The Elite membership of the drug industry use the
4 Patent Fiction as a means of creating spheres of
5 influence in the drug industry. As an example let
6 us examine the antibiotic industry.

7 DIVISION OF ANTIBIOTIC MARKET

8 We find that the precursor of the industry was
9 Penicillin which was brought to an economical state
10 of production by huge U. S. A. Government expenditures.
11 It is to-day possible to buy a sterile vial of
12 Penicillin for less than a vial of distilled water -
13 yet there are firms that make a profit at these
14 levels. Streptomycin was freely licensed by its
15 inventor so that Streptomycin can be purchased not
16 at 50¢ a gram as stated in the presentation by
17 Mr. Smith, but as low as 7¢ a gram in the sterile
18 vial.

19 IDENTICAL PRICING AND DOSAGE

20 One of the cheapest antibiotics to manufacture is
21 Chloramphenicol Chloramphenicol, yet Parke-Davis
22 in the U.S.A. enjoys a monopoly. It is of interest
23 to note that this company does not sell Tetracycline.
24 By means of a peculiar interchange of patents and
25 licenses, we find that at least 4 companies are
26 selling Tetracycline, Pfizer, Lederle, Bristol and
27 Squibb. They have some peculiar arrangements whereby
28 Pfizer holds the patent in the U.S.A., American
29 Cyanamide (Lederle) in Canada, yet Pfizer is paying
30



1 royalties to Bristol and American Cyanamide. Not to
2 be outdone the product of Erythromycine is sacrosanct to
3 Eli Lilly and Abbott. We now have a neat division of
4 the antibiotic industry. A corollary to this division
5 is that regardless of the cost of manufacture,
6 and relative potency, each antibiotic is put up
7 in a package of 16 units of 250 mg., and all priced at
8 \$9.35 per package. This is recommended as a convenient
9 dispensing unit to the physician regardless of the
10 size, weight or condition of the patient. Thus
11 economics now encroaches on the proper medical
12 practice. It is because of patents that the patent
13 holders possess a stranglehold on the industry, and
14 can stifle normal competition, and enable themselves
15 to maintain an orderly division of the drug market.
16
17

18 THE CANADIAN PHARMACEUTICAL
19 MANUFACTURERS ASSOCIATION

20 This is an assembly of 57 manufacturers. I understand
21 it is 54 now. It is admitted by their spokesman to
22 be 2/3 foreign owned and some of the other members
23 are foreign controlled.

24 CANADIAN PHARMACEUTICAL MANUFACTURERS ASSOCIATION
25 A FOREIGN LOBBY

26 Through this group in effect the bulk of the
27 pharmaceutical industry is captive to outside
28 interests. They control more than 90% of the drug
29 patents issued in Canada. They set the policy for the
30 industry. The Canadian Pharmaceutical Manufacturers



1 Association must be construed as a Foreign Lobby
2 paid for by Foreign Interest and any testimony this
3 group gives must be viewed in that light.
4

5 SYNTHESIS VERSUS COMPOUNDING

6 Because of the many comments about manufacturing
7 in Canada, it is important to draw a distinction bet-
8 ween manufacturing as being synthesis, or, the
9 manufacture of new chemicals from other chemicals,
10 or manufacturing as a system of compounding existing
11 chemicals into tablets, capsules, liquids or ointments.
12 The important element in any finished preparation
13 is the drug i.e. Tetracycline. There is no tetracycline
14 manufactured in Canada, even though this may represent
15 50% of the antibiotics used in this country.
16

17 A recent chat with a member of the Foreign Trade
18 Committee disclosed that I am not far off when I said
19 that 90% of the drugs (chemicals used in pharmacy)
20 are imported,

21 The most flourishing industry in Italy is the
22 drug industry because, in that country you cannot
23 patent a pharmaceutical. There is no reason but
24 that through proper interpretation of the patent
25 law, a similar situation could exist in Canada.

26 In Italy, a patient can buy Chloromycetin at 30¢
27 a capsule on presecrption under the Parke-Davis label.
28 Here, the Canadian must pay 60¢.

29
30 Pahe 1459 follows.....



1 ITALIAN DRUG PRICES AND INDUSTRY

2 In Italy Poulenc sells 100 Largactil to the patient
3 at \$3.20 per 100. In Canada the price is \$10.50 per
4 100.

5 If they were losing money they would not sell at these
6 prices in these countries, so they must be making
7 money, and fair profits too, because it only costs
8 2¢ to make a Chloromycetin capsule, and less than 0.2¢
9 to make a Largactil tablet. Therefore, even at the
10 Italian prices the inventor can still obtain a
11 suitable reward.

12 GOVERNMENT REGULATION OF DRUG INDUSTRY

13 Still, in the light of the above facts the
14 Brand Name Drug Manufacturers are not to be construed
15 as villains. We are living in a Free Enterprise
16 System. Unless the drug industry was to come under
17 Governmental Regulation as a Public Service Industry,
18 like the public utilities, they have every legal
19 right to what they consider to be a fair profit.
20 If the purchaser does not like the situation or the
21 price, it is up to him to combat the situation with
22 whatever legal means he has at his disposal.

23 The Brand Name Manufacturers are able to
24 maintain their position because of two gimmicks.

- 25 1. Monopolies through patents
26 2. Captive Customers.

27 Through these two factors they have been able
28 to forestall the ordinary operations of the economic
29 law of Supply and Demand.
30



INDUSTRY DEFIES ECONOMIC LAWS

There must be a law somewhere in the Economic Textbooks which states - that -

If a price is high and the profit great the beneficiary is subject to attack by someone who can offer a better value. My company recognizes this law and has thus become an economic compulsion.

This, however, had to be a calculated risk, in that, we had to be sure of our grounds regarding gimmick

#1 - The Patent Law.

In protecting their position the Canadian Pharmaceutical Manufacturers Association resorts to three tactics:

1. Research.
2. Quality Control.
3. Public Relations.
 - (a) Slandering Generic Drug Manufacturers.
 - (b) Pandering to Pharmaceutical Association Officers.
 - (c) Subsidizing Colleges and Universities.
 - (d) Propagandizing the Medical Profession.
 - (e) Institutional Brand Name Advertising.

The press is full of instances of such actions, and I will not attempt to bore the Committee by reciting chapter and verse. Our clipping service can supply hundreds of instances of material ground out by the information and public counseling service of this organization.



1
2 RESEARCH

3 Research is entirely an option of the company
4 performing this operation. If they do so, it is
5 because they deem it advisable and profitable.

6 QUALITY CONTROL

7 The subject of Quality Control is an onus on the
8 manufacturer. It is essential if he is to stay
9 in business.

10 ALL COMPANIES STARTED SMALL

11 We must further remember that there was a time
12 when all of these companies were small and humble.
13 They started with a product or two and perhaps at
14 one time could not afford research or quality control.
15 To-day through bloated profits and arrogance - they
16 indirectly say that no company without millions at
17 their disposal has a right to enter this industry.

18 AMOUNT SPENT ON PROMOTION

19 In their growth and development, they
20 prospered with excellent profits. It is a known fact
21 that about 25 per cent to 30 per cent of their
22 sales dollar is spent in propaganda and promotion.
23 In order to keep their profits down to a 15 to
24 18 per cent after taxes, it is necessary that these
25 companies spend large sums on methods of subsidization,
26 such as sponsored expense paid weekends called
27 plant visits, subsidized Golf Tournaments, expensive
28 desk gimmicks, concentrated repeat samplings. This
29 is not discussed in their defences - they would rather
30 play up the 5 to 10 per cent of the sales dollar spent



1 on research and quality control. This matter will be
2 treated separately under its proper heading. The
3 figures discussed above are typical of the mother
4 companies but are not typical of the members of the
5 Canadian Pharmaceutical Manufacturers Association.

6 VALIDITY OF STATISTICS

7 Mr. Conder was asked whether a copy of the
8 statistical compilation of their operating results would
9 be available for examination. The answer was that we
10 would have to obtain our information from the newspapers.
11 The figures given to the newspapers are obviously
12 misleading, but unless the report were available there
13 would be no means of testing the figures. A good
14 guess could be made as to how these figures were
15 arrived at.

16 It is a paradox that the members of the
17 Canadian Pharmaceutical Manufacturers Association,
18 by crying Research and Quality Control, are able
19 to spend \$1.00 for research, spend \$3.00 telling
20 the public about it and charge the public \$10.00 for
21 the privilege of listening.

22 The only redeeming feature they possess is
23 that in their expenditures for Research they incidentally
24 must accomplish some good. What price Research?

25 THE PHARMACEUTICAL ASSOCIATIONS

26 The roles and parts played by the spokesmen
27 of the collective Canadian Associations are the real
28 mystery of the Drug Issue.
29
30



1 DRUG PRICES NOT TOO HIGH

2 Their collective attitude is that drug prices
3 are not too high when one considers the Good the
4 Drugs do. One gets a mysterious feeling that the
5 Manufacturers Association has a hypnotic hold on their
6 thinking processes. The fact that all druggists
7 obtain their drugs wholesale, or perhaps in the form
8 of salesmen's samples, might render them impervious to
9 the infliction of a high cost of medication. The
10 immediate higher dollar profit is to them good
11 business. The fact as will be shown later - that this
12 is economically all wrong - never enters the mind of
13 the Association Executives. I accuse the executives
14 of the association, to be most charitable, as being
15 misguided.

16 WRONG PUBLIC RELATIONS

17 They are pulling the chestnuts out of the
18 fire for the Manufacturers Association, when they
19 should be out creating good will for the working
20 druggists and obtaining the sympathy of their fellow
21 breadwinners, which is the Public.

22 As I said before, I can understand and
23 sympathize with the motives and the objectives of
24 the Manufacturers Association, but to me it is a per-
25 petual source of wonderment to really know what
26 motivates the Pharmaceutical Association Executives.
27 Item: The Canadian Pharmaceutical Association Magazine,
28 May 1960 - headlined:
29
30



"GILBERT DENOUNCES CANADIAN PHARMACEUTICAL
ASSOCIATION PRESIDENT"

C.P.A. ATTACK ON GILBERT

They devoted three full pages in reporting anything that they might consider derogatory to me or my company. They blew up a newspaper report in which it was mentioned that the College of Pharmacy had my company up for charges for illegal dispensing of prescription.

Our attorney had written them as follows:

THE CHAIRMAN: You state "The Canadian Pharmaceutical Association". Do you mean the Manufacturers or the druggists?

MR. GILBERT: I always specify the manufacturers when I talk about the manufacturers, and if I say "the Pharmaceutical Association", I refer to the pharmacists or druggists.

THE CHAIRMAN: We are now talking about the druggists?

MR. GILBERT: That is right, or the druggists association, I am sorry.

June 29th, 1960.

The Editor,
Canadian Pharmaceutical Journal,
221 Victoria Street,
TORONTO, Ontario.

Dear Sirs: Re: Jules R. Gilbert

In your issue of May, 1960, you gave considerable publicity to certain charges against employees of my



1 client Jules R. Gilbert.

2 As the charges against this client's
3 employees have all been dismissed or withdrawn, I
4 request that in fairness, you give equal publicity
5 to this result.

6 Very truly yours,

7 JMR:b

MALCOLM ROBB.

8 It is a sad commentary that they neither replied to
9 the letter nor published the fact that the case was
10 dismissed without calling witnesses.

11 FIXED PANELS FOR DISCUSSION

12 Gentlemen; there is no bitterness about
13 this, because this is a form of war. However, much
14 better could be expected of a learned body of
15 professional men who claim to be ethical in protecting
16 public interest. - (or do they deny this?)

17 It should be mentioned in passing that members
18 of the Manufacturers Association are freely invited
19 to speak before their association meetings, and there
20 seems to be a distinct rapport and sense of
21 communion between the pharmacist and the manufacturer.

22 One association had the courage to invite me
23 to speak before their group, but after three post-
24 ponements the invitation was cancelled completely,
25 which would indicate that their thinking is either
26 totally one-sided or severely controlled....By Whom?

27 INUENDO INSTEAD OF FACTUAL RESEARCH

28 The Pharmaceutical Association has clearly
29 defined the potential of a pharmacist is being able
30



1 to judge the relative quality of drugs by means of
2 training and experience. However, all their
3 allegations and judgments re generic drugs are based
4 on hearsay, intuition and indoctrinations.

5 Of all groups this is the one group trained
6 to back up their statements by fact, but they show
7 no inclination to use their training and back up
8 their statements by fact. Instead they take the
9 easy path and say because a product has a brand name
10 and is backed by a company with large resources then we
11 can always fall back on the plea that we tried to supply
12 the best. For all I know these groups may have
13 performed tests on Generic Drug products, but their
14 findings would not prove their contentions.

15 COUNTERFEIT DRUGS

16 Investigations with the Department of
17 Health and Welfare will indicate that any number
18 of my company's products have been sent to them for
19 testing. Imagine the glee of the Association if
20 they could find something wrong. If they cannot
21 prove lack of quality, the motives of the Association
22 must be questioned. An interesting observation on
23 the presentation by Mr. Smith of ORPA on the
24 importation of counterfeit drugs, which were all
25 prescription drugs, would indicate that these were
26 purchased by pharmacists for resale on prescription.
27 Mr. Smith would have done better not to have mentioned
28 the subject
29
30



1 because it is a reflection on his brethren, who made
2 the existence of this counterfeiter possible.

3 They convict themselves of:

- 4 (a) Purchasing Drugs cheaply for purposes of
5 of substitution
6
7 (b) Buying sub-standard merchandize.
8
9 (c) Wittingly buying stolen merchandize.

10 The only group that could make a counterfeiting firm
11 prosper would be the retail druggist. Therefore,
12 it is a mistake for Mr. Smith to introduce this
13 subject as a reason for not using the Generic Drug.
14 They should clean house first.

15 ENTRAPMENT

16 THE COLLEGE OF PHARMACY

17 It has been a standing joke and pastime among
18 the employees of our organization to discuss the
19 crude efforts of the College of Pharmacy operatives
20 and inspectors in trying to incriminate my company.
21 One operative once came in with a prescription from
22 a Detroit, U.S.A. physician for an antibiotic which
23 was not produced in the strength requested. I
24 believe the attempt was designed to catch us on
25 four different counts. They have even come in disguised
26 as poor people who needed aid.

27 Finally, in desperation, they tried to
28 convert a legitimate sale to a doctor as an illegal
29 filling of a prescription. The operative tried hard
30 to get a receipt for income tax purposes, but failed
in that attempt. Charges were laid anyway and the



1 case was dismissed, but at a considerable expense
2 to our company.

3 AVOIDANCE OF ISSUES

4 The report of Mr. Hughes, Dean of the College
5 of Pharmacy was most learned, and very accurate in
6 historical presentation of pharmacy. I would rather
7 liked to have heard that his college laboratories
8 had made exhaustive tests of brand name products and
9 their generic equivalents, and then used the findings
10 to draw pertinent conclusions. That effort I would
11 consider a true public service and a scientific effort
12 to remove the clouds from the issues before this
13 Committee. If they have done so, which is a logical
14 presumption, and they are withholding their findings,
15 then as an educational body, they stand accused of
16 not truly having a public interest. If they have not
17 performed such tests, then they stand accused of
18 attempting to indoctrinate their graduates in an
19 unscientific manner, nor should they consider themselves
20 qualified to render an opinion. The college talks of
21 training their students to evaluate the quality of
22 drugs - but they seem to stop there. I notice that
23 the College gives lip service to the use of the
24 Generic name on prescriptions, but their presentation
25 indicates that the pharmacist should only dispense
26 the Brand Name drug even on such a prescription.

27 GRANTS AND SCHOLARSHIPS

28 I think that if an august body like the
29 College of Pharmacy thinks that Company sponsored
30



1 grants are vital to its existence they should come
2 out and say so - it would be understandable. It is
3 still the captive public that would be paying the
4 shot.

5 DRUG STORE ECONOMICS

6 The leanings of the College of Pharmacy
7 is portrayed in the mass of statistics presented by
8 Professor Fuller, a confessed failure in a drug
9 store operation, who now writes treatises on how to
10 succeed in drug store operation.

11 The mass of statistics are strictly designed
12 to create an impression about which practicing
13 pharmacists must inwardly chuckle. He attempts to
14 create an impression that the general drug store
15 operation subsidizes the prescription department.

16 Las week I called 5 pharmacists and asked
17 for a list of their last 25 prescriptions and their
18 selling prices. The information was culled from
19 different parts of the city. The results are
20 tabulated. Costs are conservatively estimated as
21 being higher than the best possible purchase. (see
22 statistical data on separate page).

23 I think I would like to discuss that
24 table at this point. It appears immediately following
25 the brief as table No. 1. To summarize the results
26 of this survey for Store No. 1 - incidentally, the
27 selling price was the actual selling price quoted
28 by the pharmacist on the prescription, the cost is
29 one that I estimated at the lowest, conservatively on
30



1 the basis of the smallest package that he could
2 purchase.

3 In other words, this does not consider the
4 best price.

5 In store No. 1 the total was \$91.40 for
6 25 prescriptions and the cost was \$40.21. That
7 goes along to stores No. 1, 2, 3, 4 and 5, and we
8 find \$96.10, \$85.50, \$101.55, and \$63.25.

9 I would like to comment at this particular
10 point that this was in an era of good weather and
11 there were no big antibiotic prescriptions in this
12 schedule.

13 The average prescription price was for
14 store No. 1 \$3.65 and the average cost \$1.61. For
15 the second store, \$3.84 and \$1.66. For store No.
16 3, \$3.90 as against \$1.62. Store No. 4, \$4.06 against
17 \$1.55. Store No. 5 \$2.53 as against \$.65.

18 Let us take store No. 5 which has the
19 lowest average prescription cost, which has the
20 highest percentage gross profit of 72.6 per cent.
21 It shows a paradoxical situation which exists in
22 drug prices.

23 The gross profit averaged at 56 per cent,
24 57 per cent, 58.3 per cent, 61 per cent, and 72.6
25 per cent.

26 Actually you have a high and a low there
27 and it was considered that the average result would
28 be a fairly good mean, so that we get an overall
29 average selling price of \$3.59 in a time of good
30



1 weather, and overall average cost of \$1.42 and a
2 return per prescription of \$2.17 and an average gross
3 profit of 63.9 per cent. I estimated there
4 would be roughly a ten cent charge per prescription
5 for labelling or bottling which are included in
6 the cost. In this group there were no high cost
7 antibiotic prescriptions and it was during a period
8 of exceptionally good weather.
9

10 Professor Fuller need not have been reticent
11 about the actual gross profit made on prescriptions -
12 when the full function of the pharmacist is made
13 clear the public will agree that the druggist needs
14 a better margin of profit than other retailing
15 establishments in order to stay in business. The
16 answer seems to be in the \$2.00 prescription fee.
17 A word of caution should be inserted at this point.
18 When the \$2.00 prescription fee comes in vogue the
19 pharmacist will then suddenly turn about strongly
20 in favour of the generic drug because his immediate
21 profit motive would be better served. This Mr.
22 Fuller would not like. We will then find the following
23 peculiar situation arising. A cost comparison
24 would result as follows:

25 100 Tablets Equanil or Miltown - a well known
26 tranquillizer - current price \$12.00.

27 100 Tablets Meproamate current price should be \$3.95.

28 Notice I say "should be \$3.95." This only reached
29 the one hundred category. These are divided in
30 pairs. I discussed the brand name and the equivalent



generic name and we find as follows that under the \$2.00 prescription fee schedule, the costs to the patient would be as follows: Equanil would cost \$9.20 or a reduction from \$12.00. Meprobamate would cost \$3.60, a reduction of only \$.35. Take a well known product like Amphetamine Sulf it would be \$2.40 and Benzedrine \$5.25. The cost of Chloromycetin would be \$35.60 as against \$12.00.

Quantity	100	500	1000
Equanil	\$9.20	\$38.00	\$74.00
Meprobamate	3.60	9.00	15.50
Benzedrine	5.25	17.00	32.00
Amphetamine Sulf	2.40	3.15	3.80
Chloromycetin	35.60	168.30	338.60
Chloramphenicol	12.00	52.00	102.00



1
2 MR. GILBERT: Now, apparently the
3 patient would pay for one hundred Chloromycetin
4 \$56.10, but on a \$2.00 prescription fee the level for that
5 would be \$35.60. Our Chloramphenicol would sell at
6 \$12.00. There is a volume carried through that
7 arises ---- If you estimate the price on the basis
8 of five hundred, and on the basis of ---

9 MR. WHITE: Excuse me. I am still not
10 clear on that table. This is what the amounts would
11 be to the patient using the \$2.00 prescription fees?

12 MR. GILBERT: That is right.

13 MR. WHITE: What is the cost to the
14 patient under present pricing practices?

15 MR. GILBERT: Well, Equanil would be
16 \$12.00; Benzadrine would be about the same on the
17 five milligram tablet. Sometimes it works the other
18 way. But, you can determine that by the fact that
19 it is almost a 40 per cent discount from the list,
20 which would be about \$2.00. Therefore, there would
21 be no change in the selling price, really.
22 Chloromycetin would have a list price of \$56.10 and
23 you deduct 40 per cent and then add \$2.00 and it
24 comes to \$35.60. We sell Chloramphenicol to the
25 druggist at \$10.00. Therefore, the price would
26 have to come out of the drug.

27 THE CHAIRMAN: Would you just complete
28 the answer to Mr. White. Give us the other column.
29 You have given us three examples. What is the normal
30 -- what do you say the normal prescription fee is?



1
2 You have said Equanil would be \$12.00 a hundred?

3 MR. GILBERT: That is right.

4 THE CHAIRMAN: What is Meprobamate?

5 MR. GILBERT: Well, using the prescription
6 fee schedule of the pharmacists, based on a small
7 unit package cost of one hundred tablets, it would
8 come out to \$3.60.

9 THE CHAIRMAN: \$3.60 - so there would
10 be no change there?

11 MR. GILBERT: Normally, they would
12 charge \$3.95 on a different schedule because I think
13 they would depart slightly from the schedule fees
14 on a generic drug basis.

15 THE CHAIRMAN: Are we talking about the
16 same thing?

17 MR. WHITE: The price now is \$3.95?

18 MR. GILBERT: Well, that is what I
19 said it should be - \$3.95. I didn't say it was
20 \$3.95.

21 MR. WHITE: What is the list price?

22 MR. GILBERT: Well, we do not establish
23 a list price on our drugs. We have the trade prices
24 to druggists. We sell druggists Meprobamate at
25 \$33.50 a thousand and using the 25 cent bottling charge,
26 and if we break it down to one hundred, it would come
27 down to \$1.35, plus 25 cents, or \$1.60, and if you
28 add the \$2.00 you would now have the \$3.60.

29 MR. WHITE: Is Meprobamate one of your
30 drugs?



1
2 MR. GILBERT: No. That is a generic
3 or chemical name of the prescription. We only sell
4 our drugs under the chemical name.

5 MR. BRYDEN: On the price you have
6 cited to the druggist, if there was a 40 per cent
7 markup for the drugs, it would not come to \$3.95.

8 MR. GILBERT: I beg your pardon?

9 MR. BRYDEN: On that price you have
10 just cited to the druggist, if there was a 40 per cent
11 markup on your price, it would not come to \$3.95?

12 MR. GILBERT: No. You see, we work
13 on a different basis. We sell on a net price basis
14 to the druggist. We presume that the druggist will
15 double the price and add a 75 cent prescription
16 fee. The \$1.60 on this one hundred price, I believe,
17 would be \$3.20 plus the 75 cent prescription fee.

18 MR. BRYDEN: This is some other company's
19 fees?

20 MR. GILBERT: Yes, we don't know -
21 he may give Meprobamate on the Equanil price list.
22 It is possible. Or, he may even decide to sell it
23 at \$12.00. We don't know. It is possible.

24 THE CHAIRMAN: We do not want to
25 interrupt your presentation, but we are just trying
26 to complete these figures. I think the correct
27 wording that I used in the question are the two words
28 "current price" that you talk about. We are now
29 trying to complete what current price is.

30 MR. GILBERT: Current price-----



1 THE CHAIRMAN: Secondly, is Equanil and
2 Meprobamate the same thing?

3 MR. GILBERT: The same chemical. Equanil
4 is a brand of Meprobamate.

5 THE CHAIRMAN: I see.

6 MR. GILBERT: Benzedrine is a brand of
7 Amphetamine Sulphate.

8 THE CHAIRMAN: And the same with Chloromycetin.

9 MR. GILBERT: That is a brand of Chloramphenicol.

10 THE CHAIRMAN: So, we should group these
11 in pairs. Please excuse us. We are laymen.

12 MR. GILBERT: That is all right. I offered
13 to be interrupted.

14 THE CHAIRMAN: You may proceed then.

15 MR. BRYDEN: Would you give the rest of
16 those prices. On the Benzedrine one, I did not hear
17 what you said the first time.

18 THE CHAIRMAN: They have to be grouped in
19 pairs.

20 MR. BRYDEN: I realize that, Mr. Chairman.
21 I just wanted to get the current list price. He
22 started on that.

23 MR. GILBERT: The current list price of
24 Benzedrine in that size would be about \$5.25.

25 MR. BRYDEN: Just the same as it is there?

26 MR. GILBERT: That is right.

27 MR. BRYDEN: How about on the generic...

28 MR. GILBERT: Actually on that is the list
29 price including a 25 cent packaging fee and that would
30



1 be 40 cents.

2 MR. BRYDEN: 40 cents?

3 MR. GILBERT: 40 cents.

4 MR. BRYDEN: That is the current price
5 now?

6 MR. GILBERT: He can buy Amphetamine Sulphate
7 at \$1.80 a thousand.

8 MR. BRYDEN: Chloramphenicol - what would
9 he sell that for?

10 MR. GILBERT: We sell it to the druggists
11 for \$10 a hundred. The Chloromycetin would cost
12 the druggist about \$33 or \$34, plus \$2, making it
13 \$35.60. Or, if you look at it on the basis of
14 the 16 capsule prescription, which is the normal
15 prescription, that carries a list of \$9.35. Now,
16 in that case it would probably come to the patient
17 at approximately \$7.50. On that basis, we sell it
18 to the druggist at \$10 a hundred, or if you were to
19 break it down, it would be \$1.60 for 16 capsules,
20 plus a 25 cent packaging fee. If we were to do that
21 for him, it would be \$1.85 and a \$7.50 prescription
22 on that basis would cost them \$3.85.

23 MR. BRYDEN: I am afraid I am lost. What
24 would be the price to the patient for the \$12. under
25 there for Chloramphenicol?

26 MR. GILBERT: That is the price that we give
27 it to the patient, giving a \$2 profit to the druggist.

28 MR. BRYDEN: But, if he followed the
29 standard practise?
30



1 MR. GILBERT: The standard practise would
2 be anywhere between \$20 and \$30.

3 MR. BRYDEN: For this generic term drug?

4 MR. GILBERT: That is right -- minimum
5 \$20. May I proceed?

6 THE CHAIRMAN: Yes.

7 MR. GILBERT: If we extend those figures
8 further to 500 and 1,000 purchases -- I know that no
9 prescriptions would be written on that way -- but,
10 when the public gets wise and the physician knows
11 what it is all about, they may decide to pool
12 prescriptions and buy a thousand. Then, you get
13 some ridiculous extension on this principle. So,
14 Equanil for which you pay \$9.20 per hundred would
15 sell at \$74 per thousand. So, there would be a
16 reduction of \$7.40. That is a reduction of about
17 \$18. However, in the lower cost drugs, you will
18 find that ten times as much will cost you less than
19 \$5 as much. What I am trying to bring out is that
20 the \$2 presecrption fee will ultimately result in
21 bulk purchasing because this is a good way for the
22 doctor or the patient to get drugs virtually wholesale.

23 THE CHAIRMAN: Well, we will come back
24 to that later.

25 MR. GILBERT: I will come to this again.

26 The smart public or physician will pool
27 drug purchases and virtually get them wholesale. This also
28 points up the savings that could be made by using
29 generic drugs and Professor Fuller should agree that the
30



1 pharmacist is economically better advised to make \$2.00
2 on a \$10.00 purchase than \$2.00 on a \$35.60 purchase.
3

4 Since the pharmacist loses money on prescrip-
5 tions, he should welcome a bulk purchase instead
6 of many split purchases. Some of this is said tongue
7 in cheek, but the presentation is factually possible.
8 Let us not rush into any untested panaceas..
9
10
11
12
13
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17 (Page 1482 follows)
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1
2 THE INDOCTRINATED DOCTOR

3 Concerned with Diagnosis

4 The physician's lot is an unhappy one
5 in this situation. He is generally very busy and
6 dedicated to the welfare of his patient. He doesn't
7 relish the idea of seeing his patient hamstrung by
8 high drug prices - he is primarily concerned about
9 proper diagnosis, but at the same time, feels a sense
10 of obligation to the detailmen, the beautiful literature,
11 the pre-digested reports of symptoms - diseases and
12 methods of treatment - but he thinks it is only fair
13 that he prescribe the product advertized to him.
14 There is no personal gain involved - it is the drug
15 at hand and he may not know of any alternative.

16 Sales Gimmicks

17 A report of a major drug company indicated
18 that after a subsidized golf tournament in Birmingham,
19 Alabama there was an 18% increase in sales in 30 days,
20 against a 2% increase in a similar area where no
21 tournament was held. This is classified in the expense
22 column for doctor education.

23 Free Drugs

24 It is difficult for a doctor to forget that
25 he had a wonderful all expense week-end represented
26 as a tour of a manufacturer's plant. Desk gimmicks
27 emblazoning the name of a drug or company stare at
28 him from every angle of his office. Does he need drugs
29 for personal use - It is always available without cost
30 - it is only fitting that the patient should help



1
2 such largesse exist.

3 We are selling to 4000 practicing physicians in Canada,
4 which represents better than 20% of the medical
5 profession - there are many physicians who never buy
6 drugs, therefore this is not to be construed as a
7 criticism of the profession. Still 90% or better of
8 drugs are prescribed under the Brand Name.

9 Physician's Power to prescribe any drug

10 Some Medical Associations are discussing
11 the question of Brand versus Generic name and seem
12 to be in favor of the latter. My personal discussions
13 with physicians indicate a leaning toward the lower
14 cost drug - but they have three problems:

15 (a) Inertia

16 (b) Lack of time to learn new names

17 (c) The opposition of the pharmacist.

18 Now, Mr. Chairman, and members, may I stress this point.
19 I feel it is of vital importance. There is no valid
20 medical reason for preferring the brand name to the
21 generic name. Since the pharmacist may not substitute,
22 it lies entirely within the power of the doctor to
23 settle the problem for the benefit of the public.

24 THE CHAIRMAN: I think we will have
25 five minutes.

26 --- Short recess

27
28 --- Following recess

29 THE CHAIRMAN: Before resuming I am
30



1
2 just thinking of the time factors involved, and I
3 do not want to be in a position of rushing you, Mr.
4 Gilbert, in any way at all. So let's proceed to
5 get your brief in, and then when you have finished,
6 we can talk about the time factors immediately after
7 that. How would that be?

8 MR. GILBERT: Would you desire me to
9 read any faster than I am going?

10 THE CHAIRMAN: I think we should not
11 interrupt you. We are at page 21?

12 MR. GILBERT:

13 THE HOSPITAL PHARMACIST

14 The Hospital Pharmacist is caught between
15 the pressures of his association executives which is
16 number one, and (2) the brand name drug manufacturers
17 and (3) the medical staff.
18 He is in a position to wield a powerful influence
19 in the lowering of costs in hospitals, but in general
20 avoids the responsibility. The Hospital Pharmacist
21 is, according to definition, trained to determine the
22 value of drugs - and while not in an easy position
23 to test drugs quantitatively and qualitatively, he
24 can easily test appearance, hardness of tablets, rate
25 of disintegration, and general pharmaceutical elegance.
26 The Hospital Pharmacist knows that he is in a position
27 to save at least 50% of a hospital drug bill, but on
28 the average does not take the opportunity.
29 It seems that the hospital pharmacist will only act
30 - if directed by authorities.



1
2 THE NEIGHBORHOOD DRUGGIST

3 Antagonism

4 Our company has had a few unpleasant
5 experiences with this category. We are flattered
6 in that at least they do not ignore us. A small
7 percentage of our mailings always come back with
8 requests to be removed from the mailing list.

9 To this we reply that to do so -- since we use a
10 commercial mailing list -- would be to prevent them
11 from receiving information that would be more palatable
12 to them. A few have been returned with the notation
13 "DROP DEAD" - some others remarks are unprintable.

14 To expose a group, we hope ultimately to
15 sell, may be business suicide but that is a risk we
16 have to take, because we believe that right thinking
17 druggists outnumber the die hards 7 to 3, and when
18 they fully understand the economic implications for
19 themselves and Canada, the odds will be 9 to 1.

20 Unfortunately, they never have an opportunity to
21 listen to the opposition.

22 Long Dollar Profit

23 Under the guise of protecting quality to
24 the patient, the pharmacist is enabled to protect the
25 long dollar profit. He ignores the fact that he
26 can make a higher percentage profit by dispensing the
27 Generic Drug. If he devoted his energies to main-
28 taining volume while making a higher percentage, in
29 the long run both he and his community will be enriched.

30 To give an example. On a prescription



1
2 for 100 Equanil tablets -- I guess I may be labouring
3 that drug -- against one for 100 Meprobamate tablets,
4 the pharmacist will earn \$4.80 against \$2.40. The
5 Equanil prescription will cost the patient \$8.00 more,
6 and \$5.85 will not have been spent to import the
7 higher costing Equanil and thus that amount would have
8 been left in the community for other goods or services.

9 This may not be clear here. What I mean
10 to say, if you take an isolated community, and let us
11 say you consider all their drugs are being imported,
12 to import 100 Equanil would cost the druggist \$7.20.
13 To import 100 Meprobamate would cost him \$1.60.
14 The difference of \$5.85 is not being sent out of the
15 community.

16 THE CHAIRMAN: Which community?

17 MR. GILBERT: Well, let us say if you
18 were to take the town of Saskatoon or Sarnia. They
19 spend so much for drugs per month, and if they can
20 bring it in at a lower cost, they are not sending that
21 money out, and that money is left in the community.
22 That amount would be left in the community for other
23 goods or services.

24 Economic Advantage of Generic Drug

25 An isolated community may spend \$100,000
26 per month on all drugs. If they could bring in the
27 equivalent drugs for \$50,000 per month, \$600,000
28 would be left in the community each year which will
29 result in the purchase of additional services and
30 which, since the dollar is not destroyed, must



1
2 ultimately reside in the tills of the community's
3 business men - including the druggist. Since matter
4 is neither created or destroyed, some one must make
5 up the difference. This becomes a debit to Mr. Pfizer,
6 Mr. Parke-Davis, Mr. Ciba, Mr. Schering etc., who
7 have not taken the additional money out of the
8 community. The same logic applies to the economics
9 of Canada. Based on Fair Market Values set by
10 customs many finished drugs arrive at considerably
11 higher prices than actual manufacturing costs. This
12 partially accounts for the meagre $6\frac{1}{2}\%$ profit demon-
13 strated by the members of the Canadian Pharmaceutical
14 manufacturers Association.

15 THE RIGHT THINKING DRUGGIST

16 The Ideal Druggist

17 A man who has a pride in his profession.
18 A man who applies his scientific background to his
19 daily occupation. A man who discovers facts for
20 himself. A man who feels that if his community
21 prospers, he will also prosper.
22 A man who does not prey on the ignorance of his
23 customer and is willing to give value for value received.
24 A man who exercises his judgment and feels that in
25 giving the best value to his customer, he also serves
26 himself best.
27 A man who feels that his primary obligation is to
28 his customer, the secondary one his supplier.
29 As an example of how a Right Thinking Druggist thinks,
30 I wish to publish the following letter to the editor



which appeared in the Vancouver Sun of March 16, 1960.

VANCOUVER SUN

MAR 16 1960

Able to Check

Editor, The Sun: Sir,—May I as an individual pharmacist be given an opportunity in your valued columns to dissent most vigorously from what seems to be the official policy of the Pharmaceutical Association of British Columbia in its defence of the self-styled "ethical" drug manufacturers? (In this context "ethical," like charity, covers a multitude of sins, and possesses, moreover, the miraculous power of converting dimes into dollars.)

Through some queer inversion of logic, the association — created to protect the interests of the public in just such issues as this—persists in championing the cause of expensive brand-name drugs as opposed to that of the identical and generally much cheaper non-proprietary ones recognized and described under their generic or chemical names in the British and other official pharmacopoeias, in which are also included standards of and tests for purity.

Somehow I believe—and certainly hope for the sake of my profession—that the association's ivory-towered spokesman is not reflecting the views of our members. We ought to be the last to mislead the public by resorting to specious, shallow, "ethically" inspired arguments concocted for us by those who would use us to cover up their exploitation of human illness and suffering.

Sir, is it not of some significance that a leading brand-name, Prednisone, reduced its price by 30 per cent after being under fire by an investigating committee in the U.S.?

As to the association's allegation that non-branded drugs may be inferior to branded products—is it not a cardinal principle in Canadian law that innocence is presumed until guilt is proven?

The association claims that the federal food and drugs department is unable to check drugs adequately. This I do not believe to be the case. In any case, the faculty of pharmacy at the University of B.C., if worth its salt, could assist by testing both branded and non-branded drug samples and reporting their findings to the food and drug inspectors if and when action is called for.

IVON GARCIA, PhD.

214 W. Sixth St.,
North Vancouver.

From B. C. HOSPITALS' ASSOCIATION
IN CASE YOU MISSED IT



1 As I say, I have a sympathy of interest with this pharmacy.

2 THE SCIENTIFIC DOCTOR

3 The Ideal Doctor

4 This professional man - an in my exper-
5 ience, there are many such - feels that his obligation
6 to the patient does not stop with diagnosis.

7 He feels that the cost of treatment is an integral
8 part of the good and welfare of the needy patient.

9 He will check various sources of similar drugs and
10 see to it that everything being equal - the patient
11 will get the best value.

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14 (Page 1492 follows)
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1 He will assess reports on the drugs on the basis
2 of bona fide reports written by independent,
3 unsubsidized investigators. He will recognize the
4 quality and properties of a drug by its proper or
5 chemical name. He is interested in fact not fancy.
6 He is not intimidated by sales pressure, gimmicks
7 or largesse. He sleeps well.
8

9
10 GOVERNMENTAL PURCHASING AGENCIES

11 GENERIC DRUG PREFERENCE

12
13 These comprise Provincial Purchasing, Department
14 of Defence Procurement, Department of Veterans
15 Affairs, Department of National Health and Welfare,
16 the Department of Defence Production is 100% on a
17 Generic Drug procurement basis. This department has
18 specific control on quality and appearance of all
19 drugs purchased. To successfully complete a contract
20 with this department means that you have met the
21 most rigorous standards.

22 Though there is no proof outside the department -
23 there is not a single major company doing business
24 with this department that has not suffered from
25 some kind of quality rejection at the hands of
26 this department. Our company is included in this
27 category.

28 The Department of Veterans Affairs is constantly
29 expanding their requirements for drugs under the
30 Generic Name. Provincial purchasing departments in



1 other provinces are gradually increasing their
2 requirements under the Generic name. There should be no
3 reason for half-measures in this regard - providing
4 the controls are proper.
5

6 GENERIC DRUG MANUFACTURERS

7 On this subject we can only be an expert on our
8 own company. We openly state our business - we are
9 gradually removing all brands or code names from our
10 products.

11 We are conscious - if only for self-preservation -
12 of producing a quality controlled product of elegant
13 appearance. We feel that we owe this to our customers
14 because they pay us an adequate profit for our
15 production. We find that having our own facilities and
16 controls does not increase our relative cost of prod-
17 uction.

18 We are openly combating the existing patents in this
19 industry.

20 We have no desire to upset the essential protection
21 for new developments.

22 We will gladly pay royalties to any company who will
23 settle with us on that basis.

24 In all our patent correspondence this offer has been
25 made individually and collectively - so far there are
26 no takers neither are there trial dates.

27 The only exception is the Pfizer Company who now
28 have a date set for February 16th - after at least
29 4 adjournments.

30 For the record we list below the actions to which



we received writs:

1. Parke-Davis	Chloromycetin
2. Pfizer	Tetracycline
3. Poulenc	Largactil
4. Schering	Chlortripolon
5. G. D. Searle	Propantheline
6. Ciba	Pyrabenzamine
7. Horner	Tolbutamide
8. Hoescht-Upjohn	Tolbutamide
9. American Cyanamide	Diamox Sulfadiazine Aureomycin
10. Frosst	Fleet Enema (With drawn)

We are countersuing for the time being, Frosst and Horner
under the Ontario Monopolies Act.

The document speaks for itself.

ORGANIZATIONS

such as: Canadian Council of Women
Canadian Consumers Association
The Ethnic Organizations
Labour Unions
Civil Service Organizations
Veterans Organizations
Pensioners

represent people who are militant and are voicing
their disapproval of existing drug prices. They
have fostered panel discussions and express the most
concern not about the \$3.20 average prescription
price - but about the people who must take drugs in
quantity to survive. They realize that it is small
satisfaction to the individual who must spend his
pension money on drugs, to know that the national
average, is only \$3.20 per prescription or only



1
2 \$12.00 per annum per capita.

3 The Canadian Council of Women has already passed
4 a resolution that the medical profession write
5 prescriptions by generic name.

6
7 THE PUBLIC

8 As a whole the public feels taken on the subject
9 of drug prices. Any dissatisfaction they may feel
10 towards the pharmacist is brought on by their
11 inability to get a generic drug prescription filled.
12 Unfortunately in an acute case, the patient
13 has neither the time nor inclination to seek out
14 the right thinking druggist or does not know where to
15 find him.

16 The public has it in their power to:

17 (A) Persuade the doctor - and I said
18 "persuade" advisedly - to write a prescription by
19 generic name.

20 (B) To shop the prescription or even
21 persuade pharmacists to put out a shingle stating

22 "We cheerfully fill prescriptions
23 for the best value generic drug."

24 I am sure the public would beat a path to that
25 druggist's door. This may be contrary to the
26 "ethical" policy of the College of Pharmacy.

27 That portion of the public who habitually write to
28 the press can further their cause by their own
29 activity.

30 It is the contention of my company that if the



1 public were militant in this objective, they could
2 force the situation by not remaining the captive
3 customer.

4 If the public does not do this, they have no cause
5 for complaint.

6 It is in their power to accomplish in months that which
7 will take the commission years to accomplish.

8 THE COMBINES INVESTIGATION
9 - INEFFECTUALITY

10 This organization started to collect facts over
11 three years ago.

12 This Governmental agency has their powers spelled
13 out within the Act.

14 In cases of monopoly control, they may either set
15 patents aside or force licensing arrangements. It
16 is my understanding that leadership in the committee
17 has changed hands. It is to be hoped that the new
18 head will take action. Three and a half years is
19 long enough to compile data.

20 PRESS, RADIO AND T.V.

21 COMMUNICATIONS, CO-OPERATION

22 I wish to express my appreciation to these three
23 media. I consider them faithful and honest in
24 their reporting. They have often tried to present
25 all sides of the story, but sometimes found a
26 lack of co-operation from those in favour of high
27 prices. My own treatment has been fair, co-operative
28 and considerate.

29 R E S E A R C H

30 RESEARCH EXAGGERATED IMPORTANCE



1 This completes my list on interested parties on
2 the drug question. We find that the pertinent issue
3 is always lost in a jumble of talk about research
4 and quality control.

5 The issue of whether a drug is too high in price
6 or is priced correctly always disappears in the
7 background.

8 The U.S. Government spends money in excess of
9 \$300,000,000 annually in the support of essential
10 research. Most of this money reaches universities
11 and hospitals, and it is not unknown to give grants
12 to drug manufacturers.

13 When a new patented product has reached the market
14 and become successful, much additional money is
15 spent on furthering the patents on this one product
16 in order to prevent outside competition. Parke-Davis
17 as an illustration must have 20 or more patents in
18 Canada on Chloromycetin alone. The same patents
19 also cover thousands of other compounds which will
20 never see the light of day. The attitude is - why
21 should we disturb a good thing. This feeling is
22 prevalent throughout the industry.

23 Research costs are written off as an expense in the
24 year it is performed. This year's research will
25 cover next year's products already paid for by the
26 public in purchased medication and fully 50% of the
27 expenditure is contributed by the Government in the
28 form of lost taxes.

29 It is a gruesome thought of what the picture would
30



1 be if another 10% were added to their existing gross
2 profit.

3 They must spend this money or they would be quickly
4 regulated out of business. As a matter of fact
5 if it were not for this research expenditure, they
6 would have nothing to talk about.

7 We all know where penicillin came from - the Salk
8 Vaccine - insulin. When Cancer is licked it will be
9 the public through the March of Dimes which will
10 pay for it.

11 All chemical firms do research, but unless they are
12 combined with a drug company, we hear nothing about
13 it. In this position is the Olin-Matheson-Squibb
14 combination and the American Cyanamide - Lederle
15 Groups.

16 We do not hear of Shell Oil requesting higher
17 prices and special benefits because of continually
18 striving to improve their products or creating
19 new ones through research.

20 QUALITY CONTROL

21 MAINLY STATISTICAL

22 This is a statistic which reports an analytical
23 finding. It means testing - but testing a product
24 does not improve it. It will only tell you whether
25 a product does or does not pass specifications.

26 The Canadian Pharmaceutical Manufacturers Association
27 talks about Spectrophotometers and other expensive
28 laboratory instruments in such a way as to infer that
29
30



1 every one of their members has such marvellous
2 equipment.

3 STANDARDS SET BY MANUFACTURERS

4 Nothing could be further from the truth.

5 Hoechst, in an affidavit requesting an injunction
6 on tolbutamide, made a special presentation on the
7 extensive quality controls they performed. Actually,
8 the tests could have been performed in a freshman
9 course of quantitative and qualitative chemistry.

10 When the Food and Drug Department in the U.S.A.
11 tried to tighten their controls in the industry
12 they were fought tooth and nail - successfully -
13 by the Brand Name Drug Manufacturers.

14 The U.S.P. allows a $\pm 15\%$ deviation in antibiotic
15 capsule content. This means in the same capsule
16 you will have a total deviation, that is between
17 capsules in the same lot of 30% and it would pass
18 specification. I can visualize our quality control
19 conscious manufacturers pleading their case before
20 the board - that they must have deviation if they
21 will meet specifications. Actually in our own production,
22 we shoot for a tolerance of $\pm 1\frac{1}{2}\%$.

23 Allusion leads to illusion.

24 THE TRUTH IN DRUG COSTS

25 COST COMPARISONS

26
27 A summary is presented of 150 prescription drug
28 prices.

29 These represent the last 50 prescriptions of one drug
30



1
2 store and the last prescriptions of 25 others.

3 In order not to incriminate any store, the pres-
4 criptions are numbered not in the order given -
5 the selling price is quoted and the cost is given
6 on the basis of the lowest quantity that can
7 be purchased to fill the prescription. The results
8 are tabulated and averaged out on the basis of per
9 store and total average.

10 Table 2 represents two typical invoices to hospitals
11 for our generic drugs with comparative costs for the
12 equivalent brand-name drugs.

13 The drugs in here are the totals
14 of two invoices . These are actual invoices with
15 the name of the hospital removed. This can be
16 verified. These are all popular drugs, well known
17 drugs and on an invoice price, our invoice price
18 of \$240.77, the equivalent cost under the brand-name
19 would have been \$565.53, or representing \$324.76
20 saving to the hospital. That is 125% of the cost
21 to the hospital.

22 I have worked a tabulation, which I
23 haven't put in the brief. It might amaze you people
24 to know that this cost us to produce \$71.55.

25 MR. WREN: Is that after a normal
26 discount is allowed the hospital?

27 MR. GILBERT: These are net prices.

28 Both sides are net prices. I used the 46% discount
29 to hospitals in figuring these prices.

30 MR. WHITE: 46%?



1
2 MR. GILBERT: Yes, figuring 40%
3 normal discount, less 10% sales tax. I did that
4 for convenience. Actually it would be slightly
5 higher today because they use 11% sales tax and
6 I used the figure 46% off the list price in
7 determining these figures.

8 These are all published prices so
9 there is no secrecy about them.

10 The second invoice, again for popular
11 drugs, on an expenditure of \$129.64., there is a
12 saving of \$176.14. This \$129.64 cost us \$20.75
13 to produce.

14
15 Pahe 1502 follows...
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ANGUS STONEHOUSE & CO LTD
TORONTO, ONTARIO

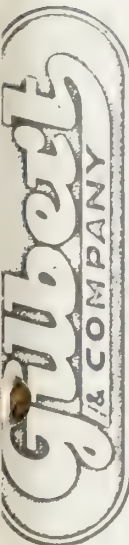
Gilbert

1963

STORE 1			STORE 2			STORE 3			STORE 4			STORE 5		
S.P.	COST		S.P.	COST		S.P.	COST		S.P.	COST		S.P.	COST	
20	3.60	1.65	6.15	3.20	1.60	.45	4.50	2.10	1.25	.20				
21	6.50	2.80	1.25	.15	1.85	.44	2.25	.50	2.50	.50				
22	2.65	1.30	2.90	1.35	2.60	.90	1.50	.20	1.95	.40				
23	2.50	.75	2.55	.50			2.95	.70	2.25	.50				
24	1.25	.25	2.85	1.25			2.50	.50	2.95	.68				
25	3.25	1.06	9.25	4.50			3.50	1.00	1.95	.30				
Total	91.40	40.21	96.10	41.45	85.80	35.75	101.55	38.65	63.25	17.48				
Average	3.65	1.61	3.84	1.66	3.90	1.62	4.06	1.55	2.53	.65				
Average per R	2.04	2.18	2.28	2.51	1.88									
Gross Profit	56%	57%	58.3%	51%	72.6%									
Over-all average Selling Price \$ 3.59														
Over-all average cost <u>1.42</u>														
Average return \$ 2.17														
AVERAGE GROSS PROFIT 63.9%														

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3701 DUNDAS ST. W.
TORONTO 9, CANADA

**SOLD**

5

SHIP TO

TERMS
NET 30 DAYS
7% INTEREST CHARGED ON OVERDUE ACCOUNTS

26951 308

CUSTOMER NO.

multivalent cost
under

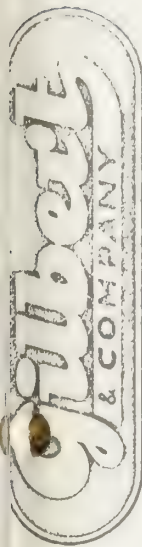
2.50

¢ 565.53	Sum
<u>249.77</u>	
¢ 324.76	

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ORDER REC'D	YOUR ORDER NO	YOUR ORDER NO	SHIP VIA	DATE SHIPPED	INVOICE NO	AMOUNT
CODE	DESCRIPTION	UNIT	QUANTITY	BACK ORDERED	SHIPPED	UNIT PRICE
081560	PROMETHAZINE 50 MG 2 AM	10	3	1	1	150
0577	PROMETHAZINE CT 10 MG	500				645
0077	PROMETHAZINE HCL 25 MG CT	500				375
0080	PROMETHAZINE SOD 1 GR CAP	500				825
0265	PROMETHAZINE SOD 3 GR CAP	500				137
0907	PROMETHAZINE SOD 5 MG CT	500				500
0901	PROMETHAZINE SOD 25 MG CAP	500				1800
0997	PROMETHAZINE SOD 1.5 GR CAP	500				485
0514	PROMETHAZINE SOD 10 MG CT	500				205
0550	PROMETHAZINE SOD 100 MG CT	500				1825
1021	PROMETHAZINE SOD 25 MG CAP	500				7525
0200	PROMETHAZINE SOD 25 MG CT	500				905
0211	PROMETHAZINE SOD 50 MG CT	500				1545
0301	PROMETHAZINE SOD 80 MG CAP	500				525

TELEPHONE
ROGER 6-9201



3701 DUNDAS ST. W
TORONTO 9, CANADA



ANGUS. STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

1505

SOLD
TO

SHIP
TO

TERMS
30 DAYS
PAID ON OVERDUE ACCOUNTS

CODE	ORDER REC'D	YOUR ORDER NO	SHIP VIA	DATE SHIPPED	INVOICE NO	QUANTITY		UNIT PRICE	AMOUNT
						BACK ORDERED	SHIPPED		
0339	000960		MAIL	91450	50822		1	24.00	24.00
0350							1	36.00	36.00
0371							1	52.10	52.10
0373							1	2.00	2.00
0307							1	50.00	50.00
0208							1	2.01	2.01

SALCS TAX EXEMPT

Equivalent cost
under
Brand Name

\$ 43.20
64.80
33.10
0.50
151.00
4.50

\$ 305.70
129.64

\$ 176.14 Swing

SPECIALTY MOORE BUSINESS FORMS LTD. PATENT PENDING



1
2 Table 3 is a comparison of more popular drugs
3 showing the difference in prices between brand-name
4 and the generic drugs.

5 I have listed most of our generic
6 popular drugs and given the hospital cost price
7 per one thousand against the generic cost price per
8 one thousand. You will find that is a fairly wide
9 representative list. I totalled the cost to the
10 hospital as being \$2,391.28 for the complete list,
11 against the cost under the generic name of \$1,037.95,
12 against the cost of production of \$264 and still we
13 can provide a saving of 56.6% of the original cost.

14 MR. WHITE: Are those prices shown
15 for the brand-name, for list prices, less 46%
16 also?

17 MR. GILBERT: That is right.

18
19
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21 Page 1507 follows....
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ANGUS, STONEHOUSE & CO. LTD
TORONTO, ONTARIO

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1/1 vba

		HOSPITAL COST PER 1000	HOSPITAL COST PER 1000 GENERIC.
1			
2			
3			
4			
5	MOD	\$80.28	\$35.20
6	TAL 1 GR.	12.90	7.00
7	IZEDRINE 10 MG.	25.92	2.80
8	OROMYCETIN 250 MG.	306.00	100.00
9	OROMYCETIN PALMITATE	2.97	1.50
10	IRIL	37.44	23.60
11	ORTRIPOLON 10 MG.	19.78	12.00
12	RGACTIL 25 MG.	3.20	17.60
13	AMYL 30	3.35	.85
14	OXIN	14.40	7.50
15	ROCORTISONE ACETATE	144.40	84.00
16	AMINE	70.00	28.00
17	SOROL 0.5	18.00	5.40
18	TANIL	58.32	13.50
19	BAXIN	64.80	36.00
20	RITRATE	8.10	3.60
21	ILONE	30.24	16.80
22	N VEE 200 M.I.U.	164.00	76.00
23	N VEE 500 M.I.U.	328.00	144.00
24	FAZOLIDINE	64.80	36.00
25	TCORTELONE	112.60	52.00
26	TCORTONE	112.60	49.60
27	ARINE 50	77.76	20.00
28	ENERGAN	28.08	16.00
29	OBANTHINE	43.20	24.00
30	JDIXIN 100	45.00	3.60
31	PASIL 25	22.32	3.00
32	IRISIN	32.40	24.00
33	HROMYCIN	306.00	150.00
34			
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DRUG	HOSPITAL COST PER 1000	HOSPITAL
		MARKET COST PER 1000 GENERIC.
EDRAL	\$19.44	\$ 5.60
PRISCILINE	34.50	6.80
OBENAL	60.48	32.00
	<u>2391.28</u>	<u>1037.95</u>

SAVINGS 56.6% OF ORIGINAL COST.



1
2 MR. GILBERT: The observations are the
3 cost to hospitals is approximately four times the
4 cost of production. Using the same basis of mark-up,
5 on brand named drugs, the cost ultimately gets to
6 the patient on the average at about 20 times the
7 cost of production. That means the cost to the
8 patient is approximately 20 times the cost of production
9 based on our cost of production.

10 I would like to make it clear when I talk
11 about cost figures I am talking about the cost of
12 the package, labelled and ready to go. Let us not
13 be confused that there is one cent of steel in
14 one thousand dollars worth of needles. I am talking
15 the finished product with the labour added and
16 everything else.

17 MR. WHITE: Would there not be incorporated
18 in that distribution and selling costs?

19 MR. GILBERT: That is right. I am talking
20 the cost of production. I can buy the material
21 and put them through my plant and show a profit on
22 these figures.

23 Table 4 is a summary of possible savings
24 to our customers and their profit ratio to druggists
25 by using generic drugs as opposed to brand name
26 drugs.

27 I will just go through two or three of
28 these to indicate how the table is worked out.
29
30



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DRUG	LIST PRICE PER 100	10% PROFIT	PRICE GENERIC EQ.	15% PROFIT	SAVING PATIENT	5	COST TO DRUGGIST
DIAMOX	\$ 14.90	40%	\$ 8.30	54.5%	\$ 6.60		\$ 3.37/c
AMYTAL 1 gr.	3.00	40%	2.65	41%	.35		.95
BENZEDRINE 10 mg.	6	40%	1.80	55%	4.60		.53
CHLOROMYCETIN 250 mg.	56.	40%	20.75		35.35		10.00
CHLOROMYCETIN SYRUP 60cc	5.50	40%	3.75		1.75		1.50
DIURIL	7.35	40%	6.00	56%	1.35		2.61
CHLORTRIPOLON	4.50	40%	3.65	62%	.85		1.45
LARGACTIL 25 mg.	10.50	40%	4.75	58%	5.75		2.01
DEXAMYL SPANSULES 30's	6.25	40%	2.40	65.5%	3.85		.83
LANOXIN	3.00	40%	2.75	64%	.25		1.00
HYDROCORTONE	29.70	40%	18.05	52%	11.65		8.65
BONAMINE	14.00	40%	6.85	55.5%	7.15		3.05
TORSOROL 0.5	6.00	40%	2.75	64%	3.35		1.00
EQUANIL	12.00	40%	4.00	57.5%	8.00		1.65
ROBAXIN	12.65	40%	8.45	54.3%	4.00		3.85
PERITRATE	3.75	40%	2.00	68%	1.75		.61
DANILONE	6.00	40%	4.60	58.2%	1.60		1.93
PEN VEE 200 MIU	33.85	40%	16.45	52.5%	17.40		7.85
PEN VEE 500 MIU	67.50	40%	30.00	51.3%	37.50		14.65



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DRUG	LIST PRICE PER 100	% PROFIT	PRICE GENERIC EQ.	% PROFIT	SAVING PATIENT	COST TO DRUGGIST
BUTAZOLIDIN	\$ 13.00	40%	\$ 8.45	54.3%	\$ 4.55	\$ 3.85
METICORTEONE	22.95	40%	11.65	53.2%	11.30	5.65
METICORTONE	22.95	40%	11.20	53.2%	11.75	5.21
SPARINE 50	15.00	40%	5.25	61.5%	9.75	2.25
PHENERGAN	5.50	40%	4.45	58.4%	1.10	1.85
PROEANTHINE	8.60	40%	6.05	56.2%	2.55	2.65
RAUDIXIN 100	10.00	40%	2.00	68%	8.00	.61
SERPASIL 25	5.75	40%	1.85	70%	3.90	.55
GANTRISIN	7.35	40%	6.05	56.2%	1.25	2.65
ACHROMYCIN	65.10	40%	30.75	51%	34.35	15.00
TEDRAL	6.00	40%	2.40	65%	3.40	.81
PRISCOLINE	5.70	40%	2.60	60%	3.10	.93
MOBENAL	12.00 <u>\$ 503.35</u>	40%	7.65 <u>\$ 250.30</u>	55%	4.85 <u>\$ 253.05</u>	3.45



1 Take diamox. The list price per hundred
2 is \$14.90 which would reflect 40 per cent profit
3 to the druggist. Using the prescription price
4 schedule, that is assuming the cost plus a 75 cent
5 prescription fee for our products, this would go
6 to the patient at \$8.30 with a 54.5 per cent profit,
7 saving the patient \$6.60 and also showing the cost
8 to the druggist in the last figure.

9 Let us go down to Largactil about 7 or
10 8 lines down. The list price per hundred is \$10.50.
11 Under the generic equivalent it should reach the
12 patient at \$4.75. The druggist makes 58 per cent
13 profit, and at that figure the savings to the
14 patient amounts to \$5.75 and the cost to the druggist
15 is \$2.01.

16 Pen Vee a well known antibiotic, 500,000
17 units, \$67.50 per hundred. The price of the generic
18 equivalent would be \$30 per hundred units and a
19 profit of 51.3 per cent to the druggist, saving the
20 patient \$37.50 and costing the druggist \$14.65.

21 I have totalled a complete list of the
22 prescriptions under each item and you can draw certain
23 conclusions. The total of \$503.35 list price per
24 hundred, the total prescriptions would amount to
25 \$503.35 with a profit of 40 per cent to the druggist.
26 Under the generic equivalent it would reach the
27 patient at \$250.30 and yield a profit of 55 per cent
28 to the pharmacist. The savings to the patient is
29 \$253.05.
30



1 A sacrifice of \$65 in profit affords a
2 saving of \$253 to the patient. If the \$253 reflected
3 itself in other store sales at 33 per cent profit,
4 there would be an additional profit of \$84 or a
5 net gain of \$19.

6
7 Table 5 is a copy of a DBS document
8 indicating imports of drugs for 1957-58 and 59.
9 This information has been extracted from the DBS
10 publication entitled "Trade of Canada Imports".

11 You can draw a bigger conclusion from this
12 table. If you take the total selling price at
13 the manufacturing level, that is at the manufacturers
14 level the wholesaler or the druggist or the hospital,
15 and you total these figures, I think you come
16 out roughly with something like ten times the mark-up
17 on the amount of raw material and import it. If
18 this is so, I think you can draw the conclusion that
19 all drugs virtually are imported into this country.
20 When you are talking about manufacturing, you are
21 talking about processing.

22 MR. BRYDEN: By processing, you mean processing
23 the bulk drugs into tablets and so on?

24 MR. GILBERT: Yes, tablets and capsules and
25 so on.
26
27
28
29
30



IMPORTS OF CHEMICALS USED MOSTLY IN

MEDICINAL AND PHARMACEUTICAL PREPARATIONS

1957

1958

1959

CHEMICAL

	Quantity	Value (\$)	Quantity	Value (\$)	Quantity	Value (\$)
Acetylsalicylic Acid	875,382	460,151	1,174,659	546,198	1,031,393	546,198
Cocaine	1,240	14,119	1,308	16,155	760	8,692
Codeine and salts	104,871	516,064	121,413	516,329	131,197	646,184
Opium and derivatives	8,031	34,218	10,601	49,697	10,269	40,905
Quinine salts	59,824	18,586	78,946	24,728	50,607	14,567
Ascorbic acid	-	273,828	-	390,958	-	410,822
Medicinal preparations dry	-	7,069,065	-	7,633,144	-	8,214,829
liquid	-	1,931,297	-	1,814,397	-	1,692,929
other	-	162,929	-	195,559	-	207,041
Menthol	-	231,950	-	236,939	-	291,916
Penicillin and products	-	833,216	-	753,887	-	1,070,129
Streptomycin and products	-	134,620	-	173,555	-	299,312
Antibiotics n.o.p.	-	4,053,970	-	4,431,941	-	4,506,202
Sulpha drugs	-	469,596	-	499,427	-	564,644
Bismuth salts	-	24,739	-	20,541	10,221	26,268
Crude iodine	93,122	100,322	80,694	77,486	111,812	99,880
Sodium bromide	51,933	16,799	79,806	24,711	87,918	28,979
Camphor	132,110	83,127	97,041	46,511	84,254	42,144
Sulphuric Ether	489,757	98,089	431,922	104,241	638,678	120,507
Malt extract	1,634,308	300,231	1,772,143	309,813	1,565,808	283,244
Nicotinic acid	45,076	99,265	20,184	49,313	53,402	91,740
Caffeine and salts	169,184	364,560	186,916	402,128	243,654	479,729
Riboflavin	-	337,207	-	370,767	-	396,150



1 THE CHAIRMAN: Well now, we have a problem.
2 Where do we go from here, gentlemen? Are there
3 any suggestions, Mr. White?

4 MR. WHITE: Mr. Chairman, I had a discussion
5 with the secretary of the Committee and the two of
6 us concluded that this particular part of the
7 Committee's work would be concluded today with the
8 result that I made certain plans for tomorrow
9 and Friday.

10 If it were agreeable to the other members
11 of the Committee, some of whom have already spoken
12 about this, if it were convenient for the witness,
13 I would suggest that we question Mr. Gilbert on his
14 presentation when we are accepting evidence and
15 questioning other drug manufacturers.

16 That is my own personal preference which
17 I put to you for consideration.

18 THE CHAIRMAN: Mr. Bryden?

19 MR. BRYDEN: I live in Toronto. It is very
20 easy for me to come here at any time.

21 THE CHAIRMAN: Mr. Wren?

22 MR. WREN: I assume this is the last brief
23 we will hear for some months?

24 THE CHAIRMAN: We always have a problem about
25 these matters. I was wondering if this is a convenient
26 time or if it is desirable or fair.

27 Firstly I would want to call you back at
28 one next hearing, Mr. Gilbert, which will probably not
29 be until spring.
30



1 I want to be scrupulously fair about this,
2 I would not do so if it were unfair to you. I put
3 it to you just that way.

4 We have problems assembling the Committee,
5 and it was our hope that the present sittings would
6 be completed at noon today.

7 MR. Trotter, have you any comments?

8 MR. TROTTER: I am here in town and I feel
9 I can make the effort to get here. I do like to
10 have some notice, at least a week. I hope there
11 will not be any more meetings this week because I
12 had not expected any tomorrow or Friday.

13 THE CHAIRMAN: That seems to be the problem some
14 of us have, too. The House will convene on November
15 22nd, and the out of town members will no doubt
16 want to get home to clean up their affairs there,
17 because of the session in sight.

18 MR. Gilbert, in your opinion if we were
19 to stop and adjourn at this point, would it affect
20 your case in any way?

21 MR. GILBERT: I have an idea that it might.
22 If you will call intervening witnesses --

23 THE CHAIRMAN: What is that?

24 MR. GILBERT: If you will call intervening
25 witnesses between now and my presentation --

26 THE CHAIRMAN: Oh, no. Immediately the
27 next session of the Committee is held you would be
28 the first, You would pick up at this point.

29 MR. GILBERT: I am entirely at the service of
30



1 the Committee.

2 THE CHAIRMAN: Would you think an adjournment
3 right at this point would affect your position?
4

5 MR. GILBERT: I do not think so. It does
6 not matter, really.

7 THE CHAIRMAN: I did not think it would,
8 myself, I must say, but I would not want to adjourn
9 without asking your advice on it.

10 MR. GILBERT: I am entirely at the service
11 of the Committee.

12 THE CHAIRMAN: I appreciate that. Are
13 there any comments about this question of adjournment
14 from anyone else?

15 MR. HUME: Mr. Chairman, I have some questions
16 to put to Mr. Gilbert on his brief, and it would
17 seem to me as if we were adjourning now and instead
18 of adjourning until tomorrow morning -- the brief is
19 half in, so to speak, and I suppose the brief should
20 be tested.

21 Unfortunately at this time, time has run
22 out. If you were looking to me for my opinion,
23 my view is that there would be no difference in adjourn-
24 ing until tomorrow morning, and if you cannot do
25 that, two or three months should not make any difference,
26 providing the record will show a continuous presenta-
27 tion and Mr. Gilbert will be on the stand for cross-
28 examination.

29 MR. TURNBULL: I am a pharmacist who has
30 practised in retail drugs and has been a supervisor



1 in the government services and have worked in wholesale,
2 and am now engaged as secretary of the Canadian
3 Pharmaceutical Association, representative of some
4 8600 pharmacists across Canada and hospital, retail,
5 industry, teaching, and all fields of pharmacy,
6 some 3700 of whom are resident in Ontario.

7 I would not want this presentation to go
8 by unless there is some type of assurance that some
9 of these points may be aired because I can in many
10 respects point out, and have proof of, incorrect
11 statements that are in that brief and reflect directly
12 upon the practise of pharmacy in Ontario and Canada,
13 and upon the Association I represent.

14 I was disappointed that we would not have
15 an opportunity to correct this before adjournment.

16 THE CHAIRMAN: The position, Mr. Turnbull,
17 is this: Mr. Gilbert's brief has been submitted
18 and at this point we will adjourn. It has not been
19 tested by our Committee's counsel on cross-examination
20 or by the members of the Committee or anyone else.
21 I think we all understand that. Mr. Gilbert does,
22 I am sure.

23 MR. GILBERT: Definitely.

24 THE CHAIRMAN: That is the position we are
25 in and if we adjourn now we will resume exactly at
26 this point on a future occasion. Would that be
27 all right, Mr. Bryden?

28 MR. BRYDEN: That is fine with me. I might
29 mention, since you will adjourn for some time that
30



1 there are two items I would like to get some information
2 on and that may take some time. If I consult the
3 secretary he can inform Mr. Gilbert and it would save
4 a delay at that time.

5 THE CHAIRMAN: I think that would be
6 fine. Without attempting to engage in any examination,
7 Mr. Gilbert, may I ask one point about your brief?
8 Are you a manufacturer only or are you a retailer?
9 I was not clear on that part of the brief. Do
10 you dispense to the public?

11 MR. GILBERT: No, we have no dealings with
12 the public.

13 THE CHAIRMAN: You are either a manufacturer
14 or a wholesaler.

15 MR. GILBERT: I might say I am an ethical
16 drug manufacturer. I put the word "ethical" first.

17 THE CHAIRMAN: But you do not have any
18 retail outlets?

19 MR. GILBERT: No, we do not sell to the
20 public.

21 THE CHAIRMAN: Gentlemen, we appear to be
22 in agreement on this. We as a Committee recognize
23 the difficulties of adjournment at this point, but
24 I see no other alternative. May I thank all those
25 have assisted us and appeared before us and who have
26 spent so much time in the preparation of these briefs
27 which contain some very valuable information.

28 All things being equal, and God willing,
29 the Committee may be reconstituted in the coming session
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of the House. Thank you. We will adjourn.

---Adjournment sine die.

Select Committee on Drugs

HEARINGS

HELD AT

PARLIAMENT BUILDINGS

TORONTO ONTARIO

VOLUME No.: *15* DATE:

15

JUNE 5 1961

OFFICIAL REPORTERS

ANGUS, STONEHOUSE & CO. LTD.

372 BAY STREET

TORONTO

EM. 4-7383 EM. 4-5865



1 SELECT COMMITTEE ON DRUGS

2
3 Proceedings of hearings
4 held at Parliament Buildings,
5 Toronto, Ontario, on Monday,
6 the 6th of June, 1961,
7 at 2.30 p.m.

8 COMMITTEE:

9 MR. H.L. ROWNTREE, Q.C. -- Chairman

10 -----
11 MR. A. WREN

12 MR. J.A. FULLERTON

13 MR. J. TROTTER

14 MR. R.E. SUTTON

15 MR. R.J. BOYER

16 MR. N. WHITNEY

17 MR. H.J. PRICE

18 MR. K. BRYDEN

19 MR. J. WHITE

20 MR. G.F. LAVERGNE

21 -----
22 MR. S.J. GADSBY, F.C.I.S., Secretary

23 MR. HAROLD A. RICE -- Committee Counsel

24 MR. W.J. AYERS -- Accounting
25 Consultant to the
26 Committee
27
28
29
30

--- Hearing resumed at 2.30 p.m.

THE CHAIRMAN: It being 2.30, we will call this Committee to order and at the outset I would state that a brief report of the previous Committee's operations citing the various parties who had appeared, and the dates on which the Committee sat, that report was filed with the Legislature and on March 15th of 1961 on my motion, and seconded by the Prime Minister it was ordered that the Committee be re-appointed and continue with the same membership and with all the same powers and duties as heretofore. Accordingly, this is the first sitting of this Committee this year since the Legislature rose. This Committee intends to visit representative hospitals from time to time, and similarly, to visit some of the manufacturing companies engaged in the manufacture and distribution of drugs, so-called drugs. How far afield we will go will be determined as time goes on.

Now we have arranged to have certain evidence produced to the Committee and if you will remember when we adjourned last at that time Mr. Jules Gilbert had completed the presentation of his company's brief, and I understand that Mr. Gilbert is here today and going to add a supplement to that brief.

Now before we proceed, are there any appearances or other matters which should be dealt with?

MR. HOWE: Mr. Chairman, my name is for the record, F.R. Howe and I am appearing for the



1
2 Canadian Pharmaceutical Manufacturers' Association. I
3 just wanted to make a brief statement, if I can, to the
4 Committee.

5 You sir and the gentlemen of the Committee
6 will remember that when the sittings terminated the
7 Association had presented an economic survey of Dr.
8 Dixon and a brief, following the questioning of Mr.
9 Conder the witness, who as you understand is unable to
10 be present here today. The members of the Committee
11 indicated that they would like to have some additional
12 information, in some cases; some expanded information
13 in other cases and perhaps in some cases a more represen-
14 tative information and I made the suggestion at that
15 time that possibly the staff of the Committee might be
16 disposed to go through the transcript and supply us
17 with a questionnaire indicating the enquiries that the
18 members of the Committee had which we would then attempt
19 to circulate among our members and would provide the
20 information.

21 For the benefit of the information of the
22 gentlemen of the Committee, the staff of the Committee
23 decided, apparently, not to submit a questionnaire but
24 notwithstanding that fact the Association, in attempting
25 to provide further information, went through the trans-
26 cript to the Committee and took out the bits of informa-
27 tion that had been asked for where the information was
28 not available and prepared a questionnaire with the
29 co-operation and assistance of Mr. A.J. Little of the
30 Clarkson Company who has been retained by the Association

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You six and the gentlemen of the Committee

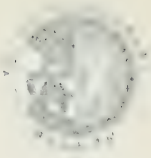
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2 for this purpose and a copy of the questionnaire is in
3 the hands, I think, of the Committee. If not, I can
4 certainly supply any additional copies of the question-
5 naire. It has been expanded to pick up all the enquiries
6 that have been asked by members of the Committee. It
7 has also been expanded to be up-dated to include 1960
8 figures, and that questionnaire was mailed out on May
9 15th last and it is expected sir that the information
10 will be available from the member companies by early in
11 July and that Mr. Little will then be in a position to
12 compile that information and present it to this Committee
13 at a date convenient to the Committee; probably when you
14 reconvene after the summer.

15 Now that simply is a brief outline of what
16 we have done, and I understand sir through your counsel
17 that, having looked at the questionnaire, it was agreed
18 that we had included everything that appeared to be
19 asked at the prior hearings and so on that basis the
20 questionnaire has gone out. The delay, if you can call
21 it that, is perhaps due to the fact that some of the
22 information would be readily available by these compa-
23 nies but other bits of information, I am advised by
24 comptrollers of the company who assisted in the prepara-
25 tion of the questionnaire will take some time to break
26 down, such as for example, the question that was asked
27 as to the percentage of sales in Ontario as opposed to
28 the whole of Canada. Now in some of the companies they
29 advised they would have to break that down by examining
30 the invoices and this took time but it is expected sir



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1
2 that this information will be available. The question-
3 naire was asked to be returned promptly. We hope to
4 have them back early in July and to be able to provide
5 the information by September. Now that was the informa-
6 tion that I understood you wanted me to advise the
7 Committee of today. I have done so. If there is a
8 question that I can answer, I would be very glad to
9 answer, with respect to this matter.

10 I have one other thing I should like to
11 say about this dealing with what we are doing to try
12 and supplement what we have done already.

13 THE CHAIRMAN: The various manufacturers
14 are still going to be available to deal with any speci-
15 fics with respect to their companies and their products?

16 MR. HUME: I imagine so sir. As you may
17 realise, I do not act for any of the individual manufac-
18 turers and have no instructions from any of them but I
19 understand that this has been planned and discussed and
20 arranged for and what I am doing has nothing really to
21 do with that matter.

22 The other matter, perhaps unless there is
23 any further questions sir I would just like to mention
24 a second matter that I should like to make a statement
25 to the Committee on.

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that this information will be available. The question-
naire was asked to be returned promptly. We hope to
have them back early in July and to be able to provide
the information by September. Now that was the informa-
tion that I understood you wanted me to advise the
Committee of today. I have done so. If there is a
question that I can answer, I would be very glad to
answer, with respect to this matter.

I have one other thing I should like to
say about this dealing with what we are doing to try
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It relates to the enquiry that is about to commence in Ottawa. I want to say two things about that. This naturally interests me as counsel for the Association, and I am advised that representations will be made to the Restrictive Trade Practices Commission.

The first matter upon which I enquired was to find out whether or not any of the statements and information contained in the statement of the director, Mr. Henry, to the Restrictive Trade Practices Commission could be used in our report in the file, and I would see that a notice from the secretary of the Commission, Mr. Smith, to the effect that this being an enquiry under section 42, and because the statement of the director was merely a statement made without taking evidence, that that statement was confidential.

THE CHAIRMAN: Section 42 of what?

MR. HUME: Of the Combines Act. They would be having public hearings, and in due course that statement would be presented and would be a public document.

Secondly, I am instructed to state to the Committee that in view of the fact that this enquiry is proceeding in Ottawa and that companies and associations will be making presentations and giving evidence, to raise the question with you, only as a question, as to whether or not it would be proper to require individual companies to come to this Committee prior to the time when they would be required to give evidence

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2 before the Restrictive Trade Practices Commission on
3 the basis that such evidence might be prejudicial.
4 I hold no brief for an individual company, but on
5 behalf of all the companies and the Association I
6 raise the question, because I am reliably informed, and
7 I imagine that your information is as complete as mine,
8 that the Restrictive Trade Practices Commission will
9 convene this summer or fall, and intend to take evidence
10 along the lines of the Combines investigation.

11 THE CHAIRMAN: Do you have any informa-
12 tion as to when the Ottawa hearings are to proceed?

13 MR. HUME: No definite information,
14 except Mr. Smith called me long distance on Thursday
15 to find out when he could expect a brief from the
16 Association, and he intimated that this was to commence
17 as quickly as possible. I took it not later than
18 September. I imagine this could be ascertained, and
19 I will be glad to do so if it would interest you.

20 THE CHAIRMAN: It would also follow that
21 some of the questions this Committee might want to
22 ask of individual companies might or might not have
23 a bearing on the Ottawa proceedings.

24 MR. HUME: I would think so sir. I
25 would think that the nature of the Ottawa investigation,
26 and without prejudging, or without really attempting
27 to indicate, other than the fact that it is an enquiry
28 under Section 42, and not an investigation, that there
29 might be a good deal in that enquiry that would be
30 of interest to this Committee, and vice versa.



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2 THE CHAIRMAN: Of course, it is rather
3 interesting that that report of Mr. Henry's is marked
4 as a private document and for the reasons you have
5 given. By the same token, the hearings before this
6 Committee are all of a public nature.

7 MR. HUME: And the hearings before that
8 Commission will be public.

9 THE CHAIRMAN: Mr. Rice, have you any
10 comments on this?

11 MR. RICE: The only comment I can make
12 is that this appears to have developed into a question
13 of policy for this Committee as to whether or not
14 in view of the Ottawa proceedings it wants to hear
15 these manufacturers, and perhaps put these questions
16 to them.

17 Also Mr. Chairman, in connection with the
18 first statement made by Mr. Hume, with regard to the
19 questionnaire, also a question of policy is involved
20 there, as to whether or not this Committee should hear
21 any of these individual manufacturers regarding this
22 questionnaire prior to hearing the report on the
23 questionnaire itself, and I would submit it would
24 perhaps be better procedure, and make better
25 chronology of the events, if we waited until we received
26 that report before we called on any manufacturer who
27 has contributed to that report. I understand the
28 report is confined to members of the Manufacturers'
29 Association.

30 THE CHAIRMAN: That is a good point. You



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2 have the questionnaire, I take it?

3 MR. RICE: Yes, I have a copy of the
4 questionnaire.

5 THE CHAIRMAN: Would this meet with your
6 approval, because it is a fact that there are some
7 manufacturers who do not belong to the Association.
8 I wonder if you might consider and discuss with Mr.
9 Ayers the possibility of getting a sampling of informa-
10 tion from drug manufacturers who are not members of
11 the Association?

12 MR. TROTTER: I hope from what Mr. Hume
13 has said it does not stop us from going ahead and
14 enquiring into the various companies that are making
15 the drugs, because unless we get the manufacturers
16 here, I think we are wasting our time, and the price
17 of drugs subject has been in the press, because it is
18 important to so many people that if we just hold off
19 it will be looked upon as an excuse just to hold off,
20 just to stall, and I think we should insist that these
21 companies come forward, so I hope that we do that.
22 Otherwise I don't think the group here is of much use
23 to anybody.

24 MR. BRYDEN: I trust it is envisaged that
25 these companies will come forward at some time. The
26 only matter of procedure, as I see it, is the
27 appropriateness of the time. Perhaps we don't have
28 to decide that at this moment. I certainly hate to
29 see a long delay in hearing from these companies, but
30 on the other hand I would not want anybody to be put in

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3 proceedings, and that they would not answer on the
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5 proceedings.

6 THE CHAIRMAN: Would this meet the
7 situation, if Mr. Rice would keep in touch with the
8 authorities in Ottawa as to dates and so on, so that
9 we can keep up to date with what is going on, having
10 in mind this time factor. Because I am not so sure
11 I haven't, it is some weeks now since I have spoken
12 to Mr. Rhodes Smith, but is it definite, Mr. Rice,
13 that, are these companies subpoenaed, or is it a
14 voluntary appearance?

15 MR. RICE: I understand they have started
16 no proceedings as yet under Section 41.

17 THE CHAIRMAN: Should not we deal with
18 this as the days develop, and we have an agenda that
19 looks like two weeks ahead of us, and maybe there will
20 be some developments by that time.

21 Does anyone else have any comment?

22 MR. WREN: One point I would like to get
23 clear. This confidential document we are referring to
24 in the hands of the Restrictive Trade Practices
25 Commission, does that embrace all drug manufacturers
26 or only those named in that document?

27 MR. RICE: The document itself is not a
28 report, it is merely a collection of material, but
29 they have collected certain material with regard to
30 drug business. There are some manufacturers in there,

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3 in the document.

4 MR. WREN: That wouldn't exclude them
5 from the investigation?

6 MR. RICE: No, the document will not
7 confine the four corners of the investigation, no.

8 THE CHAIRMAN: If there are no other
9 statements to be made, we will proceed. Mr. Gilbert.

10 When you were with us a few months ago,
11 the brief you read into the record was the one I have
12 in my hand with the green cover on it. Would you like
13 to take over from there?

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2 MR. GILBERT: I have given a little
3 thread of thought to the subject, and I thought I would
4 present a short additional statement which I would
5 like to read now.

6 Mr. Chairman and Members of the Committee,
7 the previous presentation discussed the conflicting
8 influences which had a bearing on the existing price
9 structure of drugs to hospitals and the consumers in
10 Canada.

11 The confidential report of the Combines
12 Investigation has borne out the contention that the
13 Patent Law of Canada is designed to render drug prices
14 competitive, but because of better than 90% foreign
15 control of the pharmaceutical industry, this factor has
16 not been operative. Gilbert & Company is dedicated
17 to the correction of this position, by making the
18 Canadian Patent Law operative. Plans in progress
19 should make this a reality.

20 In spite of the patent situation, there
21 is a considerable number of drugs available under the
22 generic name. The Governmental Institutions, both
23 Federal and Provincial, using drugs by Generic Name,
24 have been able to make considerable savings. The
25 Province of Ontario has reported savings in excess of
26 \$200,000 in the past year.

27 It is obvious, that if hospitals and
28 the public are to make savings, it is essential that
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2 direction should be in the public hospitals, where a
3 Generic Formulary should be made mandatory. The
4 successful operation of a Generic Formulary will in
5 time allay the fears of the Medical Profession and
6 the benefits will then accrue to the Public.

7 It is high time that the Mumbo Jumbo
8 existing in the drug industry be laid low. Medication
9 is a scientific subject which is being controlled in
10 Canada by the Foreign Drug Industry, through the fetish
11 of the Brand Name. This artifice has had considerable
12 effect in intimidating both the Medical Profession and
13 the Public.

14 Criticism without a solution is almost
15 worthless. I have considerable experience in dis-
16 cussing the matter of the Generic Drug with all
17 groups interested in dispensing and consumption of
18 drugs.

19 It has been observed that with the
20 exception of the major drug industry and their select
21 handmaidens in the pharmaceutical associations and
22 colleges, there is no disagreement.

23 The Doctor is for it.

24 The working pharmacist agrees.

25 The Hospital Services Commissions
26 think it should be mandatory.

27 The Public is awaiting the benefits.

28 With such unanimity of opinion, one
29 would expect the program to go forward. It appears
30 that there are poor lines of communication between the



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2 various groups, so that a concerted effort to resolve the
3 problem never materializes.

4 It is therefore recommended that each
5 hospital of 50 beds or over have a mandatory meeting,
6 represented by, Hospital Administration, Medical
7 Profession, Pharmacist, Purchasing Agent, a representa-
8 tive of the Hospital Services Commission, and the
9 President of the Hospital Board. It is also recommended
10 that this group be given legislative and executive
11 authority within the hospital.

12 The Agenda to be: To Give The Hospital The Optimum
13 Drug Service.

14 It then stands to reason that the
15 competitive quality controlled drug, under the Generic
16 Name, will be the Drug of choice.

17 In such a meeting any individual
18 motivations for sustaining the Brand Name Fiction
19 would fail.

20 The Hospital will be the base for
21 establishing a scientific means for drug prescribing.

22 When writing prescriptions under the
23 Generic Name becomes a habit, the advantages will then
24 naturally extend to the private patient, and the
25 various Governmental Welfare Groups.

26 Open competition will provide a natural
27 economic price level for drugs, which should be 30 to
28 40% below existing levels, while protecting the
29 operating profit necessary for the pharmacist. Economic
30 marketing of drugs even at this level should leave



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2 adequate room for a 5 to 10% allowance for research.

3 A plan of this nature, if implemented,
4 will subject the marketing of drugs to normal economic
5 laws, so that ultimately a fair price and a fair
6 profit will be available to everyone.

7 For Canada, it is most important from
8 the point of view of National Health, that an all
9 Canadian independent drug industry be developed. Our
10 company is extending all its efforts in this direction.

11 MR. RICE: Mr. Gilbert, I take it from
12 your brief that your company manufactures on the
13 generic name solely; is that correct?

14 MR. GILBERT: That is correct.

15 MR. RICE: It has no generic brand names
16 whatsoever?

17 MR. GILBERT: That is not exactly true,
18 because sometimes in a combination of drugs it is
19 impossible to put a complete list of names on the
20 label, and in a case like that we have to adopt a name
21 pretty close to the ingredients.

22 MR. RICE: Primarily you are generic
23 manufacturers?

24 MR. GILBERT: In the prime use of drugs
25 we use the generic name only.

26 MR. RICE: Does the list, the two pages
27 of this document, July, 1960, set out the list of
28 drugs that you manufacture?

29 MR. GILBERT: Part of them.

30 MR. RICE: Could you supply the Committee



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2 with the complete list of drugs that you manufacture?

3 MR. GILBERT: Yes.

4 MR. RICE: How many drugs would it be
5 that you manufacture?

6 MR. GILBERT: We have a list of
7 approximately, say, 250.

8 MR. RICE: And with that list would you
9 also supply us with the price under which you sell
10 these drugs?

11 MR. GILBERT: We have a catalogue which
12 has a price list and a schedule for discounts.

13 MR. RICE: And that is the catalogue
14 which you market and sell your drugs pursuant to?

15 MR. GILBERT: Yes.

16 MR. RICE: Do you manufacture these
17 drugs at your plant here or do you import them?

18 MR. GILBERT: What do you mean by manu-
19 facturing? That is the point. If you take the
20 concept of manufacturing as it is done in Canada, I
21 would say yes, we are manufacturing. But really I
22 think nobody is manufacturing any drugs of any
23 consequence today in Canada. There is a differentiation
24 between manufacturing the drugs and compounding the
25 drugs into a tablet or dosage form for distribution.

26 MR. RICE: What does your company do?

27 MR. GILBERT: Compound.

28 MR. RICE: What would be the total cost
29 of the investment of your company in laboratory
30 equipment?



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MR. GILBERT: I would say we have
\$100,000.00 in equipment.

MR. RICE: What would be the total cost
-- would that include all your equipment or just
laboratory equipment?

MR. GILBERT: This would include manu-
facturing equipment only.

MR. RICE: Is your plant located here
in Toronto?

MR. GILBERT: That is right.

MR. RICE: Have you any other plants than
that at Toronto?

MR. GILBERT: This is the only one at
present.

MR. RICE: Has your company developed
any drug or any drug product?

MR. GILBERT: Truly, no. We are experi-
menting with combinations of drugs, doing some work
with the Research Foundation in Saskatoon which might
be headed under research, but I wouldn't consider it
from the point of view of developing a new drug, finding
a new application in dosage form.

MR. RICE: Could you give us any idea
of what your total sales would be?

MR. GILBERT: In 1960 our drug sales
approximated about \$600,000.00. We are also in the
hospital supply field.

MR. RICE: I am talking about your sales.

MR. GILBERT: Yes, that is right.



MR. GILBERT: I would say we have

\$100,000.00 in equipment.

MR. RICE: What would be the total cost

-- would that include all your equipment or just

MR. GILBERT: This would include man-

facturing equipment only.

MR. RICE: Is your plant located here

in Toronto?

MR. GILBERT: That is right.

MR. RICE: Have you any other plants than

that at Toronto?

MR. GILBERT: This is the only one at

present.

MR. RICE: Has your company developed

any drug or any drug products?

MR. GILBERT: Truly, no. We are experi-

menting with combinations of drugs, doing some work

with the Research Foundation in Saskatoon which might

be headed under research, but I wouldn't consider it

from the point of view of developing a new drug, finding

a new application in dosage form.

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of what your total sales would be?

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1
2 MR. RICE: Where would the market be for
3 most of those drugs?

4 MR. GILBERT: Our biggest single customers
5 are the Department of Veterans Affairs and Department
6 of Production. We do sell some to pharmacists, some
7 to druggists and a fair amount to doctors directly.

8 MR. RICE: Do you market any of your
9 drugs to foreign countries, including the United States?

10 MR. GILBERT: We are in the process of
11 so doing currently. We are exporting.



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2 MR. RICE: What percentage of your sales
3 then would come from exports?

4 MR. GILBERT: This is just starting. This
5 will be a new development for us.

6 MR. RICE: Can you break down the sale of
7 \$600,000 between Ontario and the other provinces of
8 Canada?

9 MR. GILBERT: Well, it is an interesting
10 commentary on that, from the point of view, of course,
11 the Government being in Ontario and being the single
12 largest customer, would naturally mean more than half
13 of our sales would be in Ontario, but at the same time
14 we find as a peculiar thing, in the more inaccessible
15 places like the Western coast of British Columbia we
16 do obtain a large number of customers. This is an
17 interesting observation.

18 MR. RICE: Can you give us some estimate
19 as to what percentage of your \$600,000 is spent, first
20 of all, on the ingredients for your products themselves,
21 to manufacture?

22 MR. GILBERT: We figured at a broad cost,
23 at between 50 to 60% gross profit at our low cost
24 between the actual cost of the product and the packaged
25 product and the price to the consumer on the average.

26 MR. RICE: That would include ingredients,
27 the overhead cost of packaging...

28 MR. GILBERT: Not overhead, I am talking
29 strictly of ingredients, what it would cost to produce
30 a bottle of 100 aspirins, the actual cost of that I



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3 tax and overhead I do not include in that figure.

4 MR. RICE: That is about 50%?

5 MR. GILBERT: No, I figured the cost of
6 the finished product would be about 40% of the selling
7 price, 40 to 50.

8 THE CHAIRMAN: Could you just clarify
9 that for a moment, when he talks about market and
10 consumers, is the witness talking about the sales to
11 a wholesale jobber or retailer or patient?

12 MR. GILBERT: I am taking a broad average
13 on it, that is all combined.

14 MR. RICE: So 40% of the \$600,000, in
15 other words, that you were talking about...

16 MR. GILBERT: That goes to the cost of
17 the product, yes.

18 MR. RICE: What percentage of the \$600,000
19 would go to overhead?

20 MR. GILBERT: It would take another 25%.

21 MR. RICE: What percentage of the \$600,000
22 would be profit?

23 MR. GILBERT: Well, that is a difficult
24 figure to produce on a true accounting point of view.
25 Our company has gone into a lot of expenses in the past
26 year which are not normal operating expenses. Naturally
27 this would affect the profit picture, but let us say,
28 on our sales last year, the period ending 1960, we showed
29 about \$65,000 profit before taxes on a total of \$940,000
30 sales.

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2 MR. RICE: Can you tell us what percentage
3 of your total sales would go to research and development?

4 MR. GILBERT: It would be negligible.

5 MR. RICE: I take it, then, you have no
6 planned research and development programme at your
7 plant?

8 MR. GILBERT: No, with the exception of
9 donations we have pledged to certain research institu-
10 tions. That probably could be classified within that
11 category.

12 MR. RICE: Could you give us approximately
13 what percentage that would be?

14 MR. GILBERT: We pledged \$5,000 to the
15 Research Foundation of Saskatchewan.

16 MR. RICE: Is that, would that be the
17 total of your pledges for research and development?

18 MR. GILBERT: That is right.

19 MR. RICE: Now, I understand from your
20 brief that you have some type of quality control at
21 your plant?

22 MR. GILBERT: That is correct.

23 MR. RICE: Would you explain to the
24 members of the Committee just what that involves, how
25 you control the quality of your product?

26 MR. GILBERT: Our raw materials when they
27 come in are sampled at an independent laboratory. Our
28 materials are quarantined until we get a report back
29 for analysis of the quality to see it meets the full
30 U.S.P. or the appropriate monograph standard of that

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2 particular item. We carry on our own in process controls
3 within the plant. We have specific methods of setting
4 up the formulations, checking formulations, checking
5 weights of the tablets or pills as they are produced,
6 checking the disintegration and general appearance of
7 the tablets. Each stage is watched very carefully.

8 When the product is finished it is again re-sampled and
9 submitted for analysis to the independent laboratory.

10 I will say in passing this independent laboratory works
11 on a retainer basis. They do all our work. They have
12 absolutely no incentive to pass any product which is
13 sub-standard because it would only be a reflection on
14 this particular company. We are very satisfied with
15 that particular arrangement.

16 MR. RICE: Have you received any complaints
17 about the quality of your product?

18 MR. GILBERT: There have been occasions
19 where there is disputes as to analysis. Wherever customers
20 have been dissatisfied we have accepted the merchandise
21 for return. In other words, their laboratory might not
22 check with ours, but I am very confident that the
23 product that we do put out meets the analysis otherwise
24 it wouldn't go out.

25 MR. RICE: Can you tell us what percentage
26 of your product would have met with complaints?

27 MR. GILBERT: It is very rare. There
28 might have been three instances. It is interesting to
29 note that in some cases, for instance, the Department
30 of National Health and Welfare has raised objections to

particular item. We carry on our own in process controls within the plant. We have specific methods of setting up the formulations, checking formulations, checking weights of the tablets or pills as they are produced, checking the disintegration and general appearance of the tablets. Each stage is watched very carefully. When the product is finished it is again re-sampled and submitted for analysis to the independent laboratory. I will say in passing this independent laboratory works on a retainer basis. They do all our work. They have absolutely no incentive to pass any product which is sub-standard because it would only be a reflection on this particular company. We are very satisfied with that particular arrangement.

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3 have stood some improvement, and they had to take it
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5 MR. RICE: Could you tell us what percen-
6 tage of your gross sales - I am sorry, I think you
7 told us about \$600,000 was your gross return.

8 MR. GILBERT: I am talking about drugs,
9 between drugs and total sales.

10 MR. RICE: Later on you gave me \$940,000?

11 MR. GILBERT: That is all over sales.
12 That included hospital supply sales.

13 MR. RICE: We will confine our remarks
14 to the drug sales, to the \$600,000. Can you tell us
15 what percentage, what portion of that would go to main-
16 tain this quality control?

17 MR. GILBERT: I would say it would cost
18 us about \$10,000 to \$12,000.

19 MR. RICE: That would be...

20 MR. GILBERT: That is aside from the
21 help we have on the staff, that is outside expenditures.
22 In other words the staff itself does itself maintain a
23 measure of quality control. For instance, we issue our
24 labels on a numbered basis. We have a tight control on
25 our labels. We know where every pill goes to. We have
26 a batch card for each batch we produce. By reference
27 to a label we know immediately where every pill has
28 gone, very close control on our production.

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1
2 MR. RICE: Is there any way you could give
3 an estimate as to how much your money would go internally
4 to this quality control?

5 MR. GILBERT: I would add another 10,000.

6 MR. SUTTON: That figure of \$55,000 under
7 profit, some on sales, what would that profit be on the
8 \$600,000 figure? This is drugs?

9 MR. GILBERT: Well actually I figure about
10 50% gross profit. \$300,000 would be maybe in the drug
11 end alone and I think I put a little bit ahead last year;
12 it was approximately \$350,000 so you can say that the
13 major profit could be from the drug aspect of it.

14 MR. RICE: Well the percentage, as you
15 told me before for manufacturing, and so on, that would
16 be about 45% of your total sales on drugs. Would it be
17 fair to say the rest was profit?

18 MR. GILBERT: No, 45% would cover the over-
19 head. As I said before, our company has run into consi-
20 derable expense in the past year or two; the large part
21 being legal and this naturally affects the profit picture.

22 MR. RICE: Is there a constant profit on
23 your drugs? In other words, do you make as much money
24 on one of them as you do on another?

25 MR. GILBERT: No, that doesn't hold at all.

26 MR. RICE: On some drugs you make more
27 money than others?

28 MR. GILBERT: That is right.

29 MR. SUTTON: Outside of this legal expense
30 and non-recurring expense can you not estimate the



MR. RICE: Is there any way you could give an estimate as to how much your money would go into annually to this party?

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1 profit figure?

2
3 MR. GILBERT: Well if it weren't, I
4 imagine, the extraordinary expense that we ran into in
5 this business, might have added another \$75,000 to the
6 business in profit.

7 MR. BRYDEN: That is, if you had not run
8 into this unusual legal cost?

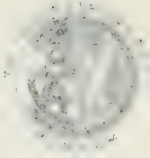
9 MR. GILBERT: That is right, and other
10 things of that nature. We employ public relations,
11 among other things. These were items that cut into the
12 profit picture.

13 MR. FULLERTON: Does the variation on the
14 profit in drugs have to do with the manufacture of one
15 certain drug as opposed to the other?

16 MR. GILBERT: I think it is strictly a
17 marketing function. I think your drug industry works
18 on what the traffic will bear type of operation. For
19 instance, if you were working on penicillins, if you
20 are going to stay in the business have to work on a
21 figure very close to cost. However, if you are selling
22 tetracycline the selling price has no relationship to
23 the cost whatsoever. You can go down 40, 50, 60, 70%
24 and still make a handsome profit. There is no rhyme
25 nor reason in this thing at all.

26 MR. BOYER: Do you supply mostly to
27 order or do you keep a stock of various drugs?

28 MR. GILBERT: We have a stocking programme,
29 an inventory programme at the plant. In other words,
30 we have a plant operating and try to keep it busy by



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1 keeping stocks on the various drugs.

2
3 MR. RICE: You told us that the percentage
4 varied from drug to drug. Could you give us the range
5 of this? The lowest profit on a drug and the highest?

6 MR. GILBERT: Well it can run anywhere
7 between 90% and 10%. Even at our levels.

8 MR. RICE: Now the materials that you
9 import, or you acquire, do you import those from foreign
10 countries?

11 MR. GILBERT: Yes.

12 MR. RICE: Or other parts of Canada?

13 MR. GILBERT: Well, we import them from
14 the United States and Europe. The biggest source is
15 primarily Italy. We do get drugs from Switzerland,
16 Holland, Denmark; little from England.

17 MR. RICE: Could you tell me what percent
18 of your drugs are imported from Italy?

19 MR. GILBERT: We will put it about 70%.

20 THE CHAIRMAN: What percent of your raw
21 materials do you buy in Canada?

22 MR. GILBERT: I would say about 10%. Well
23 actually if you look over the import status, you will
24 find that practically all the basic materials, up to
25 about 90% of the total used are imported into Canada.

26 THE CHAIRMAN: By the entire manufacturing
27 industry?

28 MR. GILBERT: That is right, and there is
29 a close relationship between that figure and the actual
30 amount of drugs that are sold in Canada based on what



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2 you might expect to be a normal market. This would
3 further bear our contention out.

4 MR. SUTTON: This figure on your imports
5 from Italy that would be unusual wouldn't it, with
6 other manufacturing sources located in Canada that could
7 draw maybe 90% from the United States?

8 MR. GILBERT: I imagine a firm like Poulenc
9 would import from Europe.

10 MR. SUTTON: But these subsidiary companies
11 of American sources ---

12 MR. GILBERT: You also have subsidiaries
13 of European companies so you would have European importa-
14 tions.

15 MR. RICE: These drugs that you import from
16 Italy are they obtainable from other countries as well?

17 MR. GILBERT: Yes.

18 MR. RICE: And Italy, it has no patent
19 law such as we have in Canada and some of the other
20 countries?

21 MR. GILBERT: I don't know whether they
22 have a patent law in Canada or not. I believe it has
23 been delegated to the proper sphere but it doesn't mean
24 anything.

25 MR. RICE: Some of these drugs that you
26 import from Italy, some of this 70% are they patented
27 in other countries?

28 MR. GILBERT: Most of them are.

29 MR. RICE: And would that be your reason
30 then for importing them from Italy rather than from



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2 other countries because there is no patent law as such
3 in Italy?

4 MR. GILBERT: We wouldn't hesitate to buy
5 from any country that would be willing to sell to us.

6 MR. RICE: Is the price for these drugs
7 you import from Italy, is it a lower price for importing
8 from Italy than other countries?

9 MR. GILBERT: Generally you will find
10 that that is a competitive market in Italy. Considerably
11 lower than you would buy from the United States as you
12 can buy tetracycline from Italy \$120 a kilo and if you
13 were to try to buy it from the United States, cost you
14 about \$280 or \$300.

15 MR. RICE: The drugs you purchased from
16 Italy they are manufactured in Italy are they?

17 MR. GILBERT: Yes.

18 MR. RICE: And if you import the same
19 drug from some other country it would be manufactured
20 in that other country?

21 MR. GILBERT: Quite possibly.

22 MR. RICE: So the cost of manufacture
23 between Italy and the other country would be a big
24 factor on what you could purchase the drug for?

25 MR. GILBERT: I don't think the cost of
26 manufacture has much to do with it. I think these
27 prices are more or less arbitrary and set by world
28 conditions, markets and patent controls rather than on
29 the basis of cost. I am talking now specifically about
30 a patent item.



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MR. GILBERT: Quite possibly.

MR. RICE: So the cost of manufacture

between Italy and the other country would be a big

factor on what you could purchase the drug for?

MR. GILBERT: I don't think the cost of

manufacture has much to do with it. I think these

prices are more or less arbitrary and set by world

conditions, markets and patent controls rather than on

the basis of cost. I am talking now specifically about

a patent item.



1
2 MR. RICE: Now on the testing of these
3 imports you have an independent firm which tests them.
4 Have you any professional people on your staff?

5 MR. GILBERT: Yes.

6 MR. RICE: Can you tell us something
7 about the personnel you have?

8 MR. GILBERT: Well our production manager
9 is a man by the name of Mr. Dix who had set up the
10 Merc plant in Valleyfield before he came with us. He
11 had just returned from the Far East where he had set
12 up other antibiotic plants, D.D.T. plants in the Far
13 East. Our packaging man also came from the Merc plant
14 in Valleyfield.

15 MR. RICE: Could you tell us what formal
16 education these men have? Have you any Ph.D's on your
17 staff?

18 MR. GILBERT: No. Mr. Dix is a chemical
19 engineer.

20 MR. RICE: That is a university degree
21 he has?

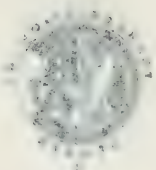
22 MR. GILBERT: Yes.

23 MR. RICE: Is he the only one with a
24 university degree on your staff?

25 MR. GILBERT: With the exception of
26 myself. Mind you, we have others with university
27 degrees but not in the production department.

28 MR. RICE: Where are the others employed
29 that have degrees?

30 MR. GILBERT: In the control department.



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1
2 MR. SUTTON: Have you any objection to
3 naming the independent laboratory?

4 MR. GILBERT: None at all. Polytechnic
5 Laboratory, 19 Cordova Street. Mr. Cowan is the man in
6 charge.

7 MR. RICE: Now moving into the next area
8 of promotion and sales, do you have a promotion and
9 sales programme with your manufacturing industry?

10 MR. GILBERT: Yes, we have a method of
11 selling by mail. Mail advertising, for the most part.
12 We do have a few salesmen, but they are small in number.
13 About four.

14 THE CHAIRMAN: We are having a little
15 difficulty hearing.

16 MR. GILBERT: I am sorry.

17 MR. BRYDEN: How many did you say you
18 had Mr. Gilbert?

19 MR. GILBERT: Four salesmen.

20 MR. BOYER: Do you call them salesmen
21 or detail men?

22 MR. GILBERT: Actually I would call them
23 salesmen. They are out to sell.

24 MR. RICE: And these salesmen, who do
25 they call on? Do they call on doctors?

26 MR. GILBERT: We recommend calling on
27 hospitals, for the most part.

28 MR. RICE: And through direct mailing,
29 who would that be directed to?

30 MR. GILBERT: Have a total mailing of



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2 about 30,000 which goes to every doctor we can reach;
3 every hospital, several pieces go to various departments
4 in the hospital and we also mail veterinarians; occas-
5 sionally we mail to dentists.

6 MR. RICE: Could you give us some idea
7 of the type of material that you mail to these people?

8 MR. GILBERT: I think you have our cata-
9 logue. This is the type of thing that is done. We
10 have others with respect to our hospital supplies. Like
11 to get something going to the hospital every two weeks.

12 MR. RICE: Do you send samples to them?

13 MR. GILBERT: Not unless requested.

14 MR. SUTTON: How many salesmen would be
15 graduate pharmacists?

16 MR. GILBERT: We have one who is a graduate
17 pharmacist.

18 MR. RICE: What qualifications have the
19 others?

20 MR. GILBERT: Experience in the surgical
21 supply field. Actually, they are not pressing the
22 drug only. They are going more after hospital supplies.

23 MR. RICE: Could you tell us what percent
24 of your total sales of your drugs, of the \$600,000,
25 would refer to this advertising promotion programme?

26 MR. GILBERT: About 10%. Since it is
27 divided between hospital supplies and drugs, I would
28 think that drugs would be about 6%.

29 MR. RICE: And can you tell us how many
30 people you have on your staff, this is apart from



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people you have on your staff, this is apart from



1
2 clerical, and so on; people actually in the production
3 end of your factory?

4 MR. GILBERT: About 10 or 12. It varies.
5 That is including packaging.

6 MR. RICE: Now can you give the Committee
7 any information as to whether or not there is any
8 confusion in identity of drugs between selling a generic
9 name and brand names?

10 MR. GILBERT: I would say absolutely none
11 because every brand name is branded by the generic name.
12 The generic name always appears on the label.

13 MR. RICE: So there shouldn't be any
14 confusion even if they use a brand name?

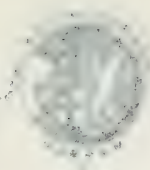
15 MR. GILBERT: Not to one who is in the
16 business.

17 MR. RICE: Now has your plant or your
18 company availed itself of the provisions of the Patent
19 Act to obtain a licence to manufacture any drug?

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MR. GILBERT: Well, we did make one attempt to get a licence, which I thought should have been granted to us, because this particular product is a product patent, and irrespective of the method of manufacture, they had control, and on that basis I thought we were entitled to a licence regardless of how the material was obtained. The patent was wrong on that ground to begin with, because in accordance with the law you cannot have a product patent. Assuming that they have a product patent, and therefore the method of manufacture is not the thing that is being patented, but the product, we thought we should be entitled to a licence on that basis. The Commissioner refused it. We appealed the case and it was directed to go back to the Commissioner, but we decided not to press it.

MR. RICE: Are you marketing that product now?

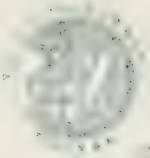
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MR. RICE: When one obtains a licence to manufacture a product, that is just the licence to manufacture the product, you don't get a licence to use the name?

MR. GILBERT: Not the name, but it is implied in the licence to manufacture.

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2 under their brand name.

3 MR. RICE: Would the price spread be
4 larger between trade name, or between generic name
5 and trade name?

6 MR. GILBERT: You will generally find
7 that the trade name products when they are similar are
8 identical in price. There is not much deviation. There
9 always is a big difference between brand name and the
10 generic name.

11 MR. RICE: Are there any instances in
12 which the generic name is more expensive than the
13 brand name?

14 MR. GILBERT: Not that I know of.

15 MR. RICE: Are there tariff rates that
16 affect imports?

17 MR. GILBERT: Well, there is a 15% duty
18 for pajcantheline not made in Canada, a 20% duty for
19 a pajcantheline made in Canada, but there is no
20 restriction as to the importation of drugs, provided
21 it meets the Approved Drug Act.

22 MR. RICE: So you could import from Italy
23 then a drug which is patented for instance in Canada?

24 MR. GILBERT: Well, some people might
25 consider it illegal, but the government does not stop
26 you.

27 MR. SUTTON: In your former brief, did
28 you mention various brand names mentioned by various
29 companies, in which the prices were identical right
30 down to the cent?

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5 that regardless of the cost of manufacture, and relative
6 potency, each antibiotic is put up in a package of
7 16 units of 250 mg., and all priced at \$9.35 per
8 package."

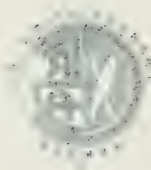
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10 since this writing, but I still think the price would be
11 identical right across the board. "This is recommended
12 as a convenient dispensing unit to the physician
13 regardless of the size, weight or condition of the
14 patient."

15 MR. SUTTON: Have you any opinions to
16 express on such a state of affairs?

17 MR. GILBERT: It sounds like a logical state
18 of affairs. I wouldn't say that in accordance with
19 the Canadian law there would be any price fixing, but
20 I think most of these things are determined at cocktail
21 hours or luncheons.

22 MR. WREN: Mr. Chairman, I am interested
23 in that point on the importation of drugs from Italy.
24 Do you know of any instances of companies who are
25 subsidiaries in Canada of American companies, where
26 they have imported the original product from Italy into
27 the United States, and then exported it to its
28 subsidiary in Canada at a higher price?

29 MR. GILBERT: I know as a matter of fact
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2 chloramphenicol from Italy for importation into the
3 United States. That is not a small amount.

4 MR. WREN: Are you aware of any portion
5 of that that would come into Canada at a higher price?

6 MR. GILBERT: It wouldn't affect the
7 price, because the price they would sell at in Canada
8 would allow plenty of profit after importation from
9 Italy.

10 MR. WREN: It was suggested American
11 firms who had subsidiaries in Canada were importing
12 from Italy at a very low price and taking advantage
13 of the low price in Italy and passing that product
14 on to their Canadian subsidiary at a forced price?

15 MR. GILBERT: It would be a businesslike
16 and a logical thing to do.

17 MR. WREN: But wouldn't it be of more
18 benefit to the Canadian consumer if the Canadian subsidiary
19 imported directly from Italy?

20 MR. GILBERT: Well, there would be less
21 money going out of the country, definitely.

22 THE CHAIRMAN: That is assuming that the
23 amount bought by the Canadian company is comparable
24 with the larger.

25 MR. RICE: On this question of prices,
26 would you tell me if there is any difference between
27 the prices of generic drugs?

28 MR. GILBERT: That is competitive. There
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2 field.

3 MR. RICE: What would the price spread
4 generally range?

5 MR. GILBERT: It can again range about
6 50% difference, up to 50%. We try to keep it about ten
7 to fifteen per cent.

8 MR. RICE: When you market your products,
9 do you give discounts for quantity sales?

10 MR. GILBERT: Well, that would come under
11 the heading of a contracting arrangement, whereby we
12 would make a special arrangement for a large sale.

13 MR. RICE: Would institutions, for instance
14 that you sell your products to, would you give them a
15 special discount because of the quantity they buy?

16 MR. GILBERT: If it comes under tender,
17 yes, there would be a special price quoted on the basis
18 of tenders. For instance, the Toronto General Hospital
19 tendered for some of their supplies today, and I know
20 of one instance. A year ago they spent about \$9,000.00
21 for what they spent \$20,000.00 today.

22 MR. RICE: Between your sales inside
23 Ontario and outside Ontario, is there a difference
24 between the price there?

25 MR. GILBERT: No.

26 MR. RICE: Regardless of where you sell,
27 you sell for the same price?

28 MR. GILBERT: That is right.

29 THE CHAIRMAN: Do you absorb the trans-
30 portation?



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3 yes.

4 THE CHAIRMAN: Regardless of the destina-
5 tion?

6 MR. GILBERT: That is right.

7 MR. RICE: And does the sales tax affect
8 the price you sell the product at?

9 MR. GILBERT: It certainly affects our
10 profit. For instance, we sell at the same price to a
11 druggist as we will to the hospital, but the druggist
12 will get the tax included and the hospital the tax
13 exempt. We get $11\frac{1}{2}\%$ less from the druggist.

14 MR. BRYDEN: So you get the benefit of
15 the hospital tax?

16 MR. GILBERT: I like to look at it that
17 we are not suffering.

18 MR. RICE: Are there any other taxes,
19 besides these sales taxes and the tariff rate, that
20 would affect your prices?

21 MR. GILBERT: Income tax, that is all.

22 MR. RICE: Turning to the brief you
23 tendered first, how many companies have you actually
24 got?

25 MR. GILBERT: We have Gilbert Surgical
26 Supply Company Limited, which is our hospital supply
27 division, and the Jules R. Gilbert Limited, which is
28 our manufacturing division. Normally we sell to the
29 public as Gilbert & Company, which is just an operating
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2 MR. RICE: Have you any retail outlets?

3 MR. GILBERT: No, none.

4 THE CHAIRMAN: Have you any interest in
5 any retail outlet?

6 MR. GILBERT: None at all.

7 MR. RICE: Is there a difference in the
8 quality of the drugs you import from Italy than the
9 same drugs imported from some other place?

10 MR. GILBERT: Generally speaking, no
11 matter where we buy it from it must meet U.S.P.
12 standards. Actually I would say you do get some of
13 the most reliable production out of Italy. Qualitywise,
14 I would say they have the most sophisticated chemical
15 industry in the world.

16 MR. BRYDEN: Is the requirement of the
17 U.S.P. standards a requirement you impose?

18 MR. GILBERT: Yes.

19 MR. BRYDEN: Another manufacturer might
20 import without such requirements?

21 MR. GILBERT: Quite likely. We buy on
22 the basis of this standard, and we have it checked
23 according to those standards.

24 MR. BRYDEN: It is possible that the
25 government might step in and pick up a shipment?

26 MR. GILBERT: Examinations are made
27 periodically, and as a matter of fact periodic examina-
28 tions are made from different manufacturers before it
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2 MR. BRYDEN: I believe they have turned
3 some shipments back?

4 MR. GILBERT: Yes.

5 MR. BRYDEN: But you yourself, or at least
6 your firm, checks all bulk drugs that are imported for
7 your use?

8 MR. GILBERT: That is right, we ourselves
9 have turned a shipment back because we were not happy
10 with it.

11 THE CHAIRMAN: In how many instances?

12 MR. GILBERT: This has only happened
13 twice.

14 THE CHAIRMAN: In what period?

15 MR. GILBERT: The past year.

16 THE CHAIRMAN: Were they large, valuable
17 shipments?

18 MR. GILBERT: They amounted to about
19 \$10,000.00.

20 MR. RICE: I take it from your brief
21 that you are not too happy with our patent division in
22 Canada as applied to the drug industry?

23 MR. GILBERT: On the contrary, I think
24 they are very good.

25 MR. RICE: In your brief you talk of
26 patent and trade names and so on would keep prices high?

27 MR. GILBERT: That is right, but there is
28 nothing wrong with the Patent Laws, just the
29 interpretation and activation of the Laws.

30 MR. RICE: Could you explain that for us?



MR. BRYDEN: I believe they have turned

some shipments back?

MR. GILBERT: Yes.

MR. BRYDEN: But you yourself, or at least

your firm, checks all bulk drugs that are imported for

your use?

MR. GILBERT: That is right, we ourselves

have turned a shipment back because we were not happy

with it.

THE CHAIRMAN: In how many instances?

MR. GILBERT: This has only happened

twice.

THE CHAIRMAN: In what periods?

MR. GILBERT: The last year.

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2 MR. GILBERT: Surely. It is possible to
3 get a licence for any product. However, the licence
4 provision isn't being activated in Canada, primarily
5 because there are relatively few manufacturing facilities
6 in Canada, but if the manufacturing facility is
7 available, there is nothing to prevent getting licences
8 for these products, and it is specifically spelled out
9 in the law.

10 MR. RICE: If the brand name drugs are
11 too high, is there anything to prevent anybody getting
12 a licence to manufacture these drugs in Canada?

13 MR. GILBERT: Absolutely not, excepting
14 the inertia of the individual.

15 MR. BRYDEN: You also have to have people
16 who know something about it?

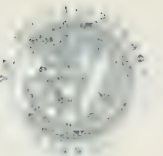
17 MR. GILBERT: I am trying to do some-
18 thing about it.

19 MR. BRYDEN: But it is not everyone who
20 is able to get into this field, because they don't
21 necessarily know enough about it, or have the capital?

22 MR. GILBERT: That wouldn't be the fault
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2 MR. BRYDEN: But the law, it may be
3 formally good, but in the practical situation it may
4 make very little difference.

5 MR. GILBERT: That actually hasn't been
6 the situation in Canada. But the specific question
7 which had been asked of me was whether the law is a
8 good or a bad one, and I say it is a good one, and it
9 is up to the manufacturers or the public to take advan-
10 tage of it.

11 MR. RICE: The Trademark Practices does
12 protect the trade name.

13 MR. GILBERT: Yes.

14 MR. RICE: And even although one did take
15 advantage of these licensing provisions in the patent
16 law, it still would not give advantage to the trade name.

17 MR. GILBERT: That is right.

18 MR. RICE: So whatever the trade name the
19 public wanted to develop, they would have to make sure
20 it was the same product as the established trade name.

21 MR. GILBERT: It is not a matter of educa-
22 tion of the public but rather one of educating the
23 doctor.

24 MR. SUTTON: I think the Kefauver Committee
25 brought out a certain spurious large shipments of drugs
26 into Canada. Was that one of them that you mentioned?

27 MR. GILBERT: No. This happened to be
28 actually the finished product that we imported, but we
29 were not happy with the aesthetic appearance of the
30 product.



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2 MR. SUTTON: Do you know about these
3 drugs which came into Canada?

4 MR. GILBERT: Only what I have read in
5 the various reports. There were some firms in the
6 United States which were actually duplicating products,
7 and I don't think it was very bad facilities for manufac-
8 turing, but there again it is the function of the pharma-
9 cists. That wouldn't be the fault of the generic manufac-
10 turer.

11 MR. SUTTON: What do you call them?

12 MR. GILBERT: Actually they were forgeries.
13 Actually they were made to look exactly like the product
14 they pretended to be. They would have the heart-shape
15 for a dexedrine product.

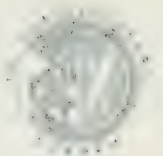
16 MR. BRYDEN: These brand names would be
17 no protection.

18 MR. GILBERT: Actually they would have
19 the same insignia on the tablet. It would be a counter-
20 feit. When they called it exactly a counterfeit, it is
21 counterfeit from the point of view of appearance, but
22 the quality could have been identical. It is just like
23 making a counterfeit gold piece out of gold.

24 MR. PRICE: But I think you mentioned
25 that the conditions under which they were manufactured
26 were found to be wanting in many respects.

27 MR. GILBERT: That is true, but it was
28 not meant to operate that way. They could afford to
29 put the nicest plant up.

30 MR. RICE: Mr. Gilbert, have you any



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2 recommendations you could make to the Committee as to
3 the prices of drugs, how they could be lowered?

4 MR. GILBERT: I have just made this
5 recommendation, that it is advisable for a hospital
6 meeting of the various interested parties to be held
7 and that they should put it into the by-laws that only
8 the generic drugs should be used, and I think when you
9 start that particular phase going I don't think you can
10 stop the spread of that practice.

11 MR. WHITE: Some months ago the Director
12 of Food and Drugs of Ottawa told us that he himself
13 would be unwilling to order drugs from his pharmacist
14 by the generic name because the foods and drugs were
15 not of a high enough standard that he could be assured
16 of a first-class product. I wonder what your comment
17 on that would be?

18 MR. GILBERT: I think I have been very
19 careful in my suggestion that they recommend that a
20 quality control drug as referring to a drug as having
21 all the aspects and appearance and quality that you
22 would expect of a drug. In other words, it might be
23 necessary to recognise certain manufacturers of meeting
24 the standards. I also understand there have got to be
25 very strict regulations put out on manufacturers, as
26 recommended by the Department of Health and Welfare.

27 MR. WHITE: But until close restrictions
28 are available, they rely on the manufacturer's good
29 name, I suppose.

30 MR. BRYDEN: Dr. Morrell wanted to know



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3 MR. GILBERT: I think it was also quoted
4 in that vein in Saskatoon last year at the Pharmaceutical
5 Convention, but the statement was very quickly retracted
6 or he claimed he was misquoted.

7 MR. WHITE: It was said that the generic
8 name itself wasn't an assurance of purity.

9 MR. GILBERT: In my own case I would be
10 happy with the most stringent regulations.

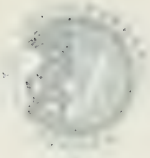
11 MR. WHITE: Until such time as there are
12 strict regulations, our hospitals have to rely on the
13 reputation of the manufacturers, because they have no
14 testing facilities of their own.

15 MR. GILBERT: I think there is a measure
16 of control from the Department of Food and Drugs where
17 the onus is on the manufacturer to produce proper
18 products. The brand name manufacturer, because of his
19 reputation, doesn't have to have any quality control.

20 MR. BRYDEN: What would you think of a
21 system of licensing of all manufacturers of prescription
22 drugs? There is already licensing for these vaccines,
23 and so on.

24 MR. GILBERT: I think that is the next
25 phase which is coming. I personally am in favour of it.
26 I think it is important in the strict controls we put
27 on the manufacturers. It may be that some wouldn't
28 pass the regulations. There may be some good ones.

29 MR. WREN: In your supplementary brief
30 you suggest, among others, the Hospital Services



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2 Commission think it should be mandatory. Where have
3 they made those observations?

4 MR. GILBERT: I have had a lot of discussion
5 with these people throughout the various provinces, and
6 I know they all feel keenly on this but they don't know
7 how to get to it.

8 MR. WREN: Are you referring to the Ontario
9 Hospitals Commission?

10 MR. GILBERT: Among others.

11 MR. WREN: It surprises me that they
12 think it mandatory.

13 MR. GILBERT: Well, to think it mandatory
14 doesn't make it mandatory.

15 MR. WREN: But they have a great deal to
16 say in the administration of hospitals, and if they
17 think it is in the interest of hospitals, I am wondering
18 why they should not offer leadership in bringing this
19 about.

20 MR. GILBERT: I think this is the purpose
21 of meetings of this nature which will ultimately give
22 them strength of conviction. If they can dispel the
23 mystery surrounding drugs.

24 THE CHAIRMAN: Why does the medical
25 profession support the trade names?

26 MR. GILBERT: It is simply a matter of
27 convenience and the fact that they sometimes have
28 difficulty in getting a generic product because of
29 the lack of co-operation from the pharmacist. We did
30 a lot of detailed work in Sarnia, a lot of doctors

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2 showed interest, but there was a definite boycott, and
3 they say: "Sorry, doctor, we don't have a supply of that.
4 Go to the next drugstore", and we let it go.

5 MR. RICE: On that point Mr. White was
2 6 referring to, is there any way they can ascertain who
7 the manufacturer of the product is?

8 MR. GILBERT: When purchased?

9 MR. RICE: When they are purchased under
10 a generic name is there any way they can tell your
11 firm's manufacture of that product from someone else?

12 MR. GILBERT: Unless you have a peculiar
13 identification of the product - of course, you can
14 always refer back to the bottle from which it is filled
15 and that determines the source. But very often tablets
16 have a different character.

17 MR. RICE: Drugs with just the generic
18 name?

19 MR. GILBERT: Very often it will give you
20 the brand name. I think there would be about a three-
21 quarter circle in this thing that ultimately may be a
22 misnomer, but you will have the brand generic drug.

23 MR. RICE: In other words, you can attach
24 the manufacturer's name to the generic name and make a
25 little longer name?

26 MR. GILBERT: It may be.

27 MR. RICE: And in that way a person who
28 is interested in the manufacture of the drug could buy
29 a generic name and still have the manufacturer of his
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2 MR. GILBERT: Yes, and in this way he can
3 control both quality and price.

4 MR. BRYDEN: Doesn't the manufacturer's
5 name have to be on the label itself?

6 MR. GILBERT: Yes, but not on the tablet.

7 MR. BRYDEN: So the tablets could
8 conceivably be interchanged?

9 MR. GILBERT: That is conceivable.

10 MR. WHITE: If the officials of the
11 hospital and the staff physicians in the hospital
12 thought that they were in danger of getting a low quality
13 drug if they ordered by a generic name through a tender-
14 ring system, how can they establish a testing system of
15 their own to make sure that the tenderer was supplying
16 what they had ordered for a small hospital?

17 MR. GILBERT: I would recommend that part
18 of their specification be that the product be submitted
19 with a laboratory report.

20 MR. BRYDEN: Would the manufacturer be
21 willing to do that?

22 MR. GILBERT: If he will tender, he will
23 do it on that basis. He knows what he is going in for.

24 MR. WREN: Would that be an expensive
25 procedure, for a small hospital?

26 MR. GILBERT: It wouldn't add to the
27 expense. As a matter of fact, the quantity would be
28 very small and it may be the part of a lot which would
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30 MR. WREN: If it was the specification

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4 MR. WHITE: What about a large hospital?

5 MR. GILBERT: Well, I have had some
6 experience with the Toronto General, and in that matter
7 the Ontario Provincial Government is doing it in the
8 same way. It is doing it on the basis of meeting the
9 analysis on the specifications which they set forth,
10 and they have it tested at their own expense; and the
11 Toronto General is doing it in the same way. But we
12 also do our own analysis.

13 MR. WHITE: But the Toronto General has it
14 tested, by their own facilities.

15 MR. GILBERT: No, I think they have it
16 done outside, I think by the Wisconsin Foundation.

17 MR. BRYDEN: You said that you considered
18 the patent law as such to be satisfactory; the only
19 trouble was that there are a few or not enough business-
20 men taking advantage of it in applying for licences and
21 that sort of thing. I understand that you yourself are
22 one who is trying to take advantage of the favourable
23 features of the patent law, but I judge from your brief
24 that you are having a rather rough time doing it.

25 MR. GILBERT: Well, we haven't had
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28 MR. BRYDEN: I got the impression that
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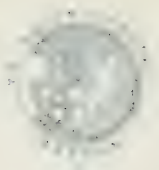
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PB/hm 1

2 MR. BRYDEN: So the law may be satisfactory
3 as it stands but taking advantage of it is not always
4 an easy process?

5 MR. GILBERT: It certain is not.

6 MR. BRYDEN: But it needs doing. Are
7 there any others that you know of besides yourself
8 that are engaged..

9 MR. GILBERT: My experience has shown
10 when one of my competitors is faced with the thing,
11 the attitude is stop that Gilbert and then I will stop.

12 MR. BRYDEN: What is the status of your
13 various law suits. I think in your original brief you
14 had ten suits against you, two counter suits by you,
15 have any of these been brought to trial?

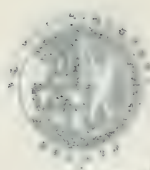
16 MR. GILBERT: February 27th, and as the
17 case was supposed to be tried, which was Pfizer, it
18 was settled on the Friday, the day before trial.

19 MR. BRYDEN: What were the drugs?

20 MR. GILBERT: Terramycin, Tetracycline --
21 we sold very little of Ocytetracycline and it didn't
22 pay us to fight that particular phase of it. We
23 accepted an injunction on that product. We also agreed
24 to the validity of their tetracycline, a patent, but
25 they in turn entered into agreement not to sue for
26 past, present or future infringement.

27 MR. BRYDEN: Past, present and future,
28 in other words they are again....

29 MR. GILBERT: You might call it a royalty
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3 large companies in the country that have a licence for
4 this product?

5 MR. GILBERT: That is right.

6 MR. BRYDEN: You are able to proceed
7 without paying?

8 MR. GILBERT: Or even import.

9 MR. BRYDEN: Are all others still pending?

10 MR. GILBERT: Yes.

11 MR. BRYDEN: Have any new suits been
12 launched against you since you were last here?

13 MR. GILBERT: One that came in last
14 Friday. They have given up trying to get an
15 action in the Exchequer Court in Ottawa and they are
16 trying in the Supreme Court in Ontario. They are
17 really trying hard. I don't know where their jurisdiction
18 comes in on patent case, but having failed every time
19 to get an injunction in Ottawa they are now trying in
20 the Supreme Court in Ottawa -- in Toronto.

21 THE CHAIRMAN: Mr. Gilbert, you were
22 speaking about generic names and the use of trade names
23 by individuals who might have a say in which product
24 is prescribed. As I understand it the theory and the
25 right to prescribe has been a time honoured right
26 of the Medical Profession. Do you disagree with that
27 right? Do you think it should be taken away from the
28 Doctors?

29 MR. GILBERT: No, I don't think it should
30 be taken away from the doctors, but I think the doctors



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3 over-exercise the right that they have. There should
4 be good reason for exercising the right. I think that
5 is one big difficulty with the Hospital Services
6 Commission. They don't want to impose regulations
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9 THE CHAIRMAN: Isn't it a matter that
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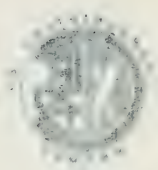
11 MR. GILBERT: Well, actually since all
12 this publicity has come about we find a patient often
13 asking the doctor to please give a prescription by the
14 generic name so they can go out shopping for the
15 prescription.

16 THE CHAIRMAN: In that case that is her
17 choice?

18 MR. GILBERT: It is the doctor's choice
19 to do so or not.

20 THE CHAIRMAN: It wouldn't be fair to take
21 you as an example, let us take Mr. Average Citizen,
22 when he goes to the doctor does he tell the doctor,
23 should he tell the doctor how to treat him?

24 MR. GILBERT: He should not tell him, he
25 should ask him to treat him in a certain way, establish
26 that principle. I am not suggesting otherwise, in
27 other words, the patient should be in the position to
28 express the willingness to accept a lower cost drug,
29 then it is up to the doctor to give it not as he sees
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2 the doctor's rights.

3 MR. BRYDEN: How do you handle the
4 problem of what might be termed as educating doctors?
5 I have read articles in medical journals to the effect
6 all the literature a doctor is shown, it would be
7 impossible for the average physician to digest it and
8 absorb it all, he becomes more and more dependent on
9 the detail man who has a vested interest, after all.
10 Have you any idea as to the way out of this difficulty?

11 MR. GILBERT: I am not a medical man.
12 I would say this: There are too many drug products
13 on the market, in fact they are creating diseases to
14 match the drugs that they produce. If the system were
15 to depend on the generic principle you will find it will
16 be an automatic limitation of the number of products
17 which will come out because of the lack of desire to
18 study too hard. There will be certain drugs to use
19 to do certain jobs he would have an opportunity to
20 really study and know the efficacy of these drugs
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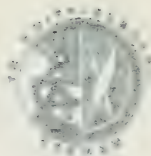
22 MR. BRYDEN: Do you know of a publication,
23 a U.S. publication called, I think is the Medical
24 Letter?

25 MR. GILBERT: I have heard of it, yes.

26 MR. BRYDEN: You have not studied it
27 at all?

28 MR. GILBERT: No, they plan to give
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30 MR. BRYDEN: I have seen copies of it.



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5 MR. GILBERT: I personally believe that
6 when the generic principle is fully established, I
7 think, medicine will be a lot better off, and they will
8 know more about what they are doing.

9 MR. TROTTER: I understand you don't
10 spend too much on research. Can you give us some idea
11 of what you think these companies that charge much
12 higher prices for drugs than you do, what they might
13 spend on research?

14 MR. GILBERT: Well, it depends on what
15 you mean by research. There are a lot of things lumped
16 under the subject of research. Actually I feel that
17 research is more commercial protection than commercial
18 production. In other words, real research -- they
19 spend their time trying to aggregate to themselves a
20 certain portion of the market and prevent anybody else
21 from encroaching on it. When you take a look at one
22 patent, they have covered five thousand compounds --
23 it would be a small patent, and of these compounds they
24 will only put one on the market while they will keep
25 on research in the endeavour to enclose the field as
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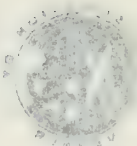
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4 A man should be protected for his developments, but
5 by the same token you have these people who have
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7 money and the big strength of the patent is their
8 ability to prevent contesting the patent by the weight
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10 a peculiar thing, I mean the verity or the truth of
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14 had the benefit of let us say ten or twelve years and
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19 MR. TROTTER: That is why I was wondering
20 how you would say the Patent Law with the licensing
21 system is a good Patent Law when it seems so difficult
22 to adminstrate.

23 MR. GILBERT: The provisions are there.

24 MR. BRYDEN: Until you came along nobody
25 challenged them so the patents were unchallenged
26 whether valid or not.

27 MR. TROTTER: I would think as a business
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7 haven't got the funds or the willingness or desire,
8 I think they find it desirable to avoid the market and
9 maintain prices. That is the only reason it is not
10 activated.

11 MR. TROTTER: Could you give us an idea from
12 your experience as to what the large company might
13 spend on research? By research I mean the improvement
14 of drugs or the finding of new drugs?

15 MR. GILBERT: Improvement of drugs, that
16 is if you mean changing molecular composition, I
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23 What they do is true research and what the companies
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25 essentially, of protecting their marketing advantage.

26 MR. TROTTER: If the American Government
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14 can you tell us if you have any idea of what percentage
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18 MR. GILBERT: Do mean American solely
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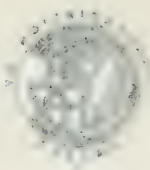
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21 there was 90% foreign control?

22 MR. GILBERT: That is right.

23 MR. TROTTER: I would like to know what
24 percentage of that is from the United States?

25 MR. GILBERT: This would be a guess,
26 I would say about two-thirds of that figure, maybe
27 60%.

28 MR. TROTTER: Sixty per cent of all the
29 drug industry in Canada, about two-thirds. Is there
30 any particular reason why we in Canada cannot manufacture



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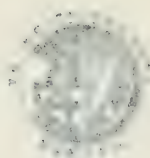
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7 MR. BRYDEN: What companies or organiza-
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11 MR. GILBERT: They manufacture their own
12 vaccine and serum. I think mostly they are making
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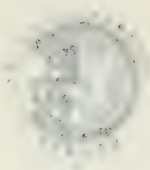
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17 Connaught Laboratories?

18 MR. GILBERT: You have I think two or
19 three small chemical manufacturing companies. The type
20 of fine chemical and I think Ayerst, McKenna and Harri-
21 son in Montreal are actually making drugs. Mostly we
22 find that they are segregating their production to two
23 or three firms.

24 MR. BRYDEN: Are they under contract to
25 these firms do you know?

26 MR. GILBERT: Well they wouldn't do
27 anything to hurt their feelings, let's say.

28 MR. WREN: Mr. Chairman, this witness
29 may be the only one we have that is in an allied field,
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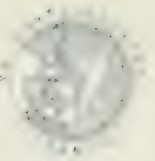


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3 expressed about the price of this equipment supplied.
4 The Prime Minister last session expressed some horror
5 at the cost of hospital equipment, the nature of instru-
6 ments and that sort of thing. Do you think they are
7 inordinately high in the trade generally?

8 MR. GILBERT: Well when going through the
9 regular channels, drawing a parallel to the drug
10 industry, these things do come at a high price and I
11 think the brand name effect really goes into play there
12 too. As a case in point, we once had difficulty with
13 Becton and Dickenson on syringes. They cut us off so
14 we took the liberty of importing the syringe which
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16 dealers' price. It was a good quality syringe. No
17 difficulty. In fact, I personally thought it was
18 superior to the American syringe, and we find that
19 instead of working on 15% on the Becton and Dickenson
20 product we could save about 40% to the hospital and
21 make about 60%.

22 MR. WREN: I don't know, in my experience
23 on hospital boards certain instruments which a mechanic
24 might have in the garage and might cost \$1, but at the
25 moment it is chromium plated by hospital supply firms
26 it's \$4. Is that a general practice?

27 MR. GILBERT: I think you will find that
28 if the hospitals are really interested, let us say, in
29 improving purchasing of the drugs on the basis of
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3 degree as in the drug industry. That's a bit fabulous.
4 I mean this doesn't often happen but there is a consi-
5 derable saving that could be made in the hospital
6 supplies using the same basis of purchase.

7 MR. WREN: Do you know that from
8 experience?

9 MR. GILBERT: That is right.

10 MR. WHITE: Mr. Gilbert in the supplemen-
11 tary brief you say that if a hospital were to establish
12 a generic drug formula they would save 30 to 40% on
13 their drug cost. How do you support that figure?

14 MR. GILBERT: I think I support it in
15 my brief here where I give an illustration of the
16 number of drugs that they are selling. As a matter of
17 fact, I have got two typical invoices in my brief,
18 page 38 and 39. I think from that you will see it
19 would take \$565 for the brand name, take \$240 under
20 the generic. This is without any special price or any-
21 thing. I mean without competitive tenders. This is
22 based on normal price and the saving would be \$324.
23 The same way on the next page, on \$305 invoice the
24 saving would be \$176. This is in excess of 50%. As I
25 mentioned - excuse me - this particular order with the
26 Toronto General may actually save about 70%.

27 MR. WHITE: Why do you say 30 or 40?

28 MR. GILBERT: Being generous.

29 MR. WHITE: In other words, it might be
30 50 or 60?



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2 MR. GILBERT: And more.

3 MR. WHITE: This is just a rough estimate?

4 MR. GILBERT: Well I am just giving you
5 something. I don't want to sound too radical.

6 MR. RICE: Mr. Gilbert I have been asked
7 to put this question to you. I thought I dealt with
8 this right at the commencement. Do you sell under any
9 trade name?

10 MR. GILBERT: Way back we started by abbrevi-
11 ating the generic name. For instance secobarbital we
12 might have called secobarb. Within the past two years
13 we converted all our labels to the strict generic name,
14 with the exception of products which have more than one
15 ingredient in them. In other words, you can't put a
16 generic name on a vitamin tablet, let us say, or a
17 tablet which may have 30 ingredients in it.

18 MR. RICE: What products do you manufacture
19 which would come within this exception?

20 MR. GILBERT: I would say about 10%. No
21 more.

22 MR. RICE: It follows from that, are the
23 drugs manufactured under the trade name are they all
24 available under generic names?

25 MR. GILBERT: Not all.

26 MR. RICE: Not all so there are some
27 instances that you have to buy by trade name?

28 MR. GILBERT: Yes, that is right.

29 MR. RICE: And could you tell us a ratio
30 of manufacture, of generic manufacture to trade name



15. WITNESSES: This is a rough statement

MR. GILBERT: Well I am just giving you

something. I don't want to sound too radical.

MR. RICE: Mr. Gilbert I have been asked

to put this question to you. I thought I dealt with

this right at the commencement. Do you sell under any

trade names?

MR. GILBERT: Well when we started by copre-

viewing the generic name. For instance ascorbic acid we

might have called ascorbic. At the time past two years

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3 MR. GILBERT: Well some of the so-called
4 generic manufacturers still adopt a practice of putting
5 their products under a brand name.

6 MR. RICE: So they may do both?

7 MR. GILBERT: I think we have to draw a
8 distinction as to - are you away from the fixed price
9 classification to the competitive classification because
10 brand name itself is not the only criterion.

11 MR. RICE: At the present then I take it
12 there is no way of establishing a ratio?

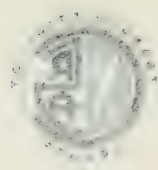
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14 there wouldn't be because some of the generic manufac-
15 turers are using brand names.

16 MR. RICE: And I suppose conversely some
17 of the trade name manufacturers are using generic names?

18 MR. GILBERT: That is right.

19 MR. BRYDEN: Mr. Gilbert you have told us
20 a substantial part of your business is with two depart-
21 ments of the Federal Government. I have no doubt that
22 there have been a good many cases where you underbid
23 some of the brand houses. Are there any instances that
24 you could cite or have you any instances where you under-
25 bid one of those houses and then a little later they
26 came back and underbid you?

27 MR. GILBERT: Well they are also bidding
28 on the United States Government, strangely enough, and
29 we lost a bid to Shering on their drug neticorten. If
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3 MR. BRYDEN: Have you ever had any
4 experience of underbidding them in the same field, for
5 the same drug?

6 MR. GILBERT: We have taken business of
7 that nature in Canada but not in the United States but
8 it gives you an illustration. I mean there is a speci-
2 9 fic case where a company will go after business and
10 make a profit on that particular item. It gives you a
11 good indication of what the actual cost of the drug is.
12 90 cents a 100 against \$22 to the patient. And sold to
13 the Government on that basis.

14 THE CHAIRMAN: That is the United States
15 Government?

16 MR. GILBERT: Yes.

17 MR. BRYDEN: Can you think of any
18 instance in the Federal Government selling to either
19 Health and Welfare and Veterans' Affairs - Health and
20 Welfare and Veterans' Affairs are the two big depart-
21 ments I think are they?

22 MR. GILBERT: Yes. I think there will be
23 a case where they will underbid ultimately. I mean
24 actually when you stop to think of it the drug shouldn't
25 cost them any more; probably cost them less.

26 MR. BRYDEN: I was just wondering if
27 there are any cases where they revised their price
28 schedule after you came into the field?

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30 bid on tetracycline to one of the major manufacturers

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3 me the second time.

4 MR. WREN: When an institution calls for
5 tenders, after the award is made, do they make public
6 the information of who bid and what amount they bid?

7 MR. GILBERT: You are referring to the
8 Government there of course?

9 MR. WREN: Yes.

10 MR. GILBERT: You can always get price
11 information from the Government provided you are a
12 bidder.

13 MR. WHITE: If the hospital were to call
14 tenders on all its drug requirements and if the hospital
15 required an independent laboratory report to accompany
16 the tender, I presume the hospital would have to make
17 sure the independent testing laboratory would still
18 have the prime facilities and could do high standard
19 testing. Have to control the testing laboratory would
20 they not?

21 MR. GILBERT: Well it is perfectly possible
22 to do it. I mean there is no reason if the system does
23 go into effect, I presume there would be certain controls
24 where they would recognise certain laboratories as being
25 acceptable to them.

26 MR. WHITE: That isn't done now?

27 MR. GILBERT: No. However, when they
28 are so doing, even if it isn't a recognised laboratory
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3 name or even that the drug is good.

4 MR. WHITE: Calling for an independent
5 testing laboratory report is just removing the question
6 of quality one step further back?

7 MR. GILBERT: That is right.

8 MR. WHITE: It wouldn't help hospitals
9 unless they knew the control?

10 MR. GILBERT: I think they would do a
11 much better service than they are doing today. Let's
12 face it, a brand name isn't a guarantee.

13 MR. BRYDEN: Of course they could specify
14 the laboratory that is to be used. Is there any reason
15 in calling for tenders they couldn't say it must bear
16 a certificate from a certain range of laboratories?

17 MR. GILBERT: They could very well do it.
18 I mean the purchaser is entitled to set up his own
19 standards in asking for a tender and it is up to the
20 bidder to agree or not to agree.

21 MR. PRICE: Do you think bidders would
22 be willing to meet those requirements?

23 MR. GILBERT: I think they would be. Mind
24 you, they might have their own analytical report. I
25 think personally they would rather have an independent
26 report.

27 MR. WHITE: How expensive would it be for
28 a hospital to test its own drug supplies?

29 MR. GILBERT: I got a bill for testing
30 tetracycline from the Toronto General Hospital and it

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2 amounted to about \$100. Now it represents several
3 thousand dollars. It is not a significant item.

4 MR. WHITE: I mean supposing a hospital
5 were to do it with its own facilities would that be an
6 expensive operation?

7 MR. GILBERT: I would say that it should
8 not be. I mean you have the specifications set up in
9 the U.S.P. for testing it and if they have the essential
10 laboratory equipment, it is just a question of time.

11 MR. WHITE: You think it is practical?
12 Why doesn't the Toronto General do its own testing?

13 MR. GILBERT: Maybe they are scared by
14 the fact it is a drug. I don't know. There is no real
15 reason for it.

16 MR. WHITE: Why don't you do your own?

17 MR. GILBERT: For two reasons: first of
18 all, I think I can give a better service in having an
19 independent laboratory test it and I find it also econo-
20 mic to do it that way. When my production grows, which
21 I hope it will, then I probably will wind up with my
22 own laboratory.

23 MR. BRYDEN: Your sales on drugs last
24 year were about \$600,000. How does that compare with
25 other companies? Where do you rank in the scale in
26 Canada, roughly?

27 MR. GILBERT: In the lower echelon I
28 suppose I rank pretty well. There is no relationship
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5 in one year.

6 THE CHAIRMAN: Mr. Gilbert it may well be
7 that on some later occasion we would want the benefit
8 of your observations but in the meantime I think that
9 would conclude the sitting for this afternoon and we
10 will resume at 2.30 tomorrow.

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12 --- Hearing adjourned at 4.20 p.m.
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HELD AT

PARLIAMENT BUILDINGS

TORONTO ONTARIO

VOLUME No.: DATE:

16

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Tuesday,
the 6th day of June, 1961,
at 2.30 p.m.

COMMITTEE:

MR. H.L. ROWNTREE, Q.C. -- Chairman

MR. A. WREN

MR. J.A. FULLERTON

MR. J. TROTTER

MR. R. E. SUTTON

MR. R. J. BOYER

MR. N. WHITNEY

MR. H.J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G.F. LAVERGNE

MR. S. J. GADSBY, F.C.I.S., Secretary

MR. HAROLD A. RICE -- Committee Counsel

MR. W. J. AYERS -- Accounting
Consultant to the
Committee

Committee of Hearings
at Parliament Buildings,
Toronto, Ontario, on Tuesday,
5th day of June, 1961.

COMMITTEE:

MR. J. A. FULLERTON

MR. R. E. SUTTON

MR. N. WHITNEY

MR. HAROLD A. RICE

Committee
Consulting to the
Government



A/AG/hm 1

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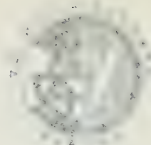
3
4 MR. RICE: Mr. Chairman and members of
5 the Council, we have first this afternoon Mr. Moisley,
6 who is the Registrar-Treasurer of the Ontario College
7 of Pharmacy, and he would like to present a letter to
8 you in rebuttal to statements made by Mr. Jules R.
9 Gilbert.

10 MR. MOISLEY: Mr. Chairman and members
11 of the Committee. As Mr. Rice has stated, I am
12 P. T. Moisley, Registrar of the Ontario College of
13 Pharmacy since March 1959. After your last sessions,
14 on instruction of the Council of the College, I asked
15 Mr. Gadsby for permission to submit a letter in
16 rebuttal of certain statements that Mr. Gilbert had
17 made on October the 26th. That permission was granted,
18 and therefore, with your permission, I would like to
19 present this letter and have it read into the trans-
20 cript of the proceedings of this Committee.

21 It is addressed to Mr. Gadsby.

22 On the afternoon of October 26, 1960
23 during the hearings of your Committee, Mr. Jules R.
24 Gilbert presented a Brief in which specific reference
25 was made to the Ontario College of Pharmacy.

26 May we respectfully request permission
27 to table with your Committee a short comment on
28 statements by Mr. Gilbert as they appeared in the
29 Transcript of Proceedings, Volume 14, dated October
30 26, 1960:



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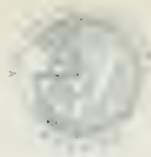
statements by Mr. Gilbert as they appeared in the

Transcript of Proceedings, Volume I, dated October

26, 1960:



1.
Reference is made to "the crude efforts of the Ontario College of Pharmacy operatives and inspectors in trying to incriminate my company". (Page 1467, lines 17 and 18, Volume 14 of Transcript)
Our efforts are governed by the rules and regulations of The Pharmacy Act, which is a provincial statute that includes provisions designed by legislators to safeguard the public. In our routine checking and investigation of wholesale and retail outlets, Mr. Gilbert's operations were checked in the normal way.
2.
Reference is made to an operative who came in with a prescription from a Detroit physician for an antibiotic which was not produced in the strength requested. (Page 1467, lines 20 to 22, Volume 14 of Transcript) Neither Inspector Greenfield nor any College employee was involved in any such case and we have no knowledge of the case referred to. The College was not involved as Mr. Gilbert claims.
3.
Mr. Gilbert comments that "they have even come in disguised as poor people who needed aid". (Page 1467, lines 24 and 25, Volume 14 of Transcript) No one authorized by the College has ever used these tactics.
4.
Finally, Mr. Gilbert refers to a court



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4. Finally, Mr. Gilbert refers to a court



2 case dismissal by saying "in desperation
3 they tried to convert a legitimate sale
4 to a doctor as an illegal filling of a
5 prescription". (Page 1467, lines 26 and
6 27, Volume 14 of Transcript) We resent
7 the implication that the College would do
8 anything so underhanded in carrying out its
9 work for the protection of the public.

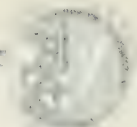
10 From time to time, we investigate complaints
11 concerning distributors making direct sales
12 to patients contrary to The Pharmacy Act
13 and in some cases prosecutions follow.
14 Needless to say, a conviction is not
15 always registered.

16 The College must continue to be vigilant
17 in checking any source of drugs and prescriptions it
18 is authorized and required to supervise.

19 Our prime concern is to provide the best
20 possible protection for the public within our limited
21 means to do so and if Mr. Gilbert's or any other such
22 establishment comes under the regulations of The
23 Pharmacy Act, then it is subject to such checking.

24 Respectfully submitted, signed by myself
25 under the direction and authorization of the Council
26 of the College.

27 MR. RICE: While you are here, perhaps
28 we could get some further information about the Ontario
29 College of Pharmacy. You pointed out in your brief this
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6 MR. MOISLEY: It has no function to do
7 with the under-graduate students. That was turned
8 over to the Faculty of Pharmacy in the University of
9 Toronto in 1953.

10 MR. RICE: How is the Council composed?

11 MR. MOISLEY: It has sixteen members.

12 MR. RICE: How are they acquired?

13 MR. MOISLEY: Fifteen are elected from
14 the districts as set out in the Act for a service of
15 two years, by a mailed ballot, and the man elected in
16 each district serves for two years. Plus the Dean
17 of the Faculty of Pharmacy of the University of Toronto.

18 MR. RICE: Who are members of this
19 College of Pharmacy?

20 MR. MOISLEY: All practising pharmacists.

21 MR. RICE: And does this Council elect --

22 MR. MOISLEY: A president and a vice-
23 president.

24 MR. RICE: The College then also controls
25 the licensing of the practising pharmacists in Ontario?

26 MR. MOISLEY: The College is now a
27 licensing and disciplining body only, with the
28 exception that it is charged with the continuing
29 education of the practising pharmacists.

30 MR. RICE: It has a disciplining committee



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1
2 attached to it?

3 MR. MOISLEY: Yes.

4 MR. RICE: How many men are on this
5 disciplining committee?

6 MR. MOISLEY: Seven.

7 MR. RICE: Is there any appeal from that
8 disciplining committee?

9 MR. MOISLEY: Yes.

10 MR. RICE: To the Supreme Court?

11 MR. MOISLEY: It is provided in the Act
12 sir.

13 MR. RICE: Are there any schools now
14 operated under the College directly?

15 MR. MOISLEY: No sir.

16 MR. RICE: As Registrar of the College,
17 could you tell us how many new graduates you are entering
18 on the rolls each year as practising pharmacists?

19 MR. MOISLEY: The graduating class of
20 the Faculty of Pharmacy varies. I think this year it
21 was 104. It may go as high as 120 or 125.

22 MR. RICE: The School of Pharmacy is
23 attached to the University of Toronto?

24 MR. MOISLEY: The Faculty of Pharmacy
25 of the University of Toronto.

26 MR. RICE: Is there any other university
27 in Ontario which has a faculty of pharmacy?

28 MR. MOISLEY: No.

29 MR. RICE: So the University of Toronto
30 Faculty of Pharmacy is the only place where pharmacists



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MR. MOISLEY: Yes.

MR. RICE: How many men are on this

disciplining committee?

MR. MOISLEY: Seven.

MR. RICE: Is there any appeal from that

disciplining committee?

MR. MOISLEY: Yes.

MR. RICE: To the Supreme Court?

MR. MOISLEY: It is provided in the Act

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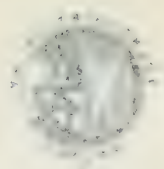
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2 can be licensed to practise in Ontario?

3 MR. MOISLEY: No, that is not true.

4 Arrangements may be made for pharmacists from other
5 provinces to practise in Ontario.
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2 MR. RICE: I mean apart from other
3 provinces, Ontario is the only school.

4 MR. MOISLEY: Yes.

5 MR. RICE: How many did you say you were
6 entering annually on your rolls?

7 MR. MOISLEY: From 74 to 125, depending
8 on the number of graduates.

9 MR. RICE: How many deletions through
10 retirement and otherwise would you have on your rolls?

11 MR. MOISLEY: That we can't say. As
12 people die and men go out of business their names are
13 taken off the register, unless they want to continue
14 doing part-time work. A man doing part-time business
15 maybe gets on the roll.

16 MR. RICE: Are the number of graduate
17 pharmacists that are entering into practice each year
18 keeping up with the increase in population and also
19 keeping up with retirement?

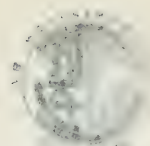
20 MR. MOISLEY: No, they are not.

21 MR. RICE: If it required approximately
22 125 pharmacists a year to replace the natural loss
23 caused by death and retirement from business, are we
24 not getting that many pharmacists?

25 MR. MOISLEY: No.

26 MR. RICE: Now, is it also prescribed in
27 the Pharmacy Act the books and records that pharmacists
28 must keep?

29 MR. MOISLEY: No, not necessarily in the
30 Pharmacy Act, because other acts are involved also.



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2 MR. RICE: Does the Council of the Ontario
3 College of Pharmacy prescribe any books and records?

4 MR. MOISLEY: Certain records are pres-
5 cribed under the Province of Ontario, certain registra-
6 tion of barbiturates, and so on. Other drugs come
7 under other acts, which are mostly federal.

8 MR. RICE: Can you tell me how many are
9 entitled to practise pharmacy in Ontario?

10 MR. MOISLEY: At the end of May it stood
11 at 3,900.

12 MR. RICE: Is there any register kept of
13 the number of pharmacists, that is retail outlets?

14 MR. MOISLEY: No, not necessarily. We
15 register the pharmacist, not the pharmacy.

16 MR. RICE: There are no records in your
17 establishment as to that number?

18 MR. MOISLEY: We could estimate a fairly
19 accurate figure. We don't register the pharmacy.

20 MR. RICE: Can you give your estimate as
21 to the number?

22 MR. MOISLEY: I believe that is covered
23 in the brief you will be hearing later on.

24 MR. RICE: Does the College have any
25 control over hospitals or institutions?

26 MR. MOISLEY: No, sir. There is an excep-
27 tion.

28 MR. RICE: Is there also an exception in
29 the Act which interferes with the practice of medicine?

30 MR. MOISLEY: No, not at all.



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2 MR. WHITNEY: Are you inferring that a
3 pharmacist in a hospital is not required --

4 MR. MOISLEY: He is not under the Pharmacy
5 Act. He is allowed under the federal acts as to the
6 purchase of narcotics. If a pharmacist wishes to buy
7 narcotics for a hospital he must be registered with us.

8 MR. WHITNEY: And licensed by it.

9 MR. MOISLEY: Yes.

10 MR. RICE: Does the College have a
11 special committee on prescription pricing?

12 MR. MOISLEY: Yes.

13 MR. RICE: Would it be better to get
14 information on that from Mr. Greenfield?

15 MR. MOISLEY: That is in his report.

16 MR. SUTTON: A registered pharmacist
17 acting as a detail man, is he registered with you?

18 MR. MOISLEY: Not necessarily. Many are,
19 many more are not.

20 MR. SUTTON: Of the 3,900 members, do
21 you know approximately how many are practising pharma-
22 cists?

23 MR. MOISLEY: Those figures are in Mr.
24 Greenfield's brief also.

25 MR. WHITE: May I ask if you check manu-
26 facturers or compounders with the wholesalers and
27 retailers?

28 MR. MOISLEY: What are you getting at?

29 MR. WHITE: Your brief says you check
30 and investigate wholesale and retail outlets, and I am



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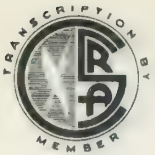
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1 asking if you check the manufacturers' premises or
2 compounds?

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4 MR. MOISLEY: No. Mr. Gilbert was only
5 on complaint. We have no powers to inspect pharma-
6 cists manufacturing as such.

7 MR. WHITE: Mr. Gilbert led us to believe
8 that it was in wholesale. You have checked Mr. Gilbert's
9 operations, but only on complaint. Would you have much
10 occasion to check any other compounders' or manufacturers'
11 premises?

12 MR. MOISLEY: Not until we receive a
13 complaint.

14 MR. WHITE: Have you received a complaint
15 about Parke Davis or Kaiser or anyone else?

16 MR. MOISLEY: No.

17 MR. WHITE: Mr. Gilbert's is the only one
18 you have had occasion to investigate?

19 MR. MOISLEY: That I can remember, in my
20 time.

21 MR. WHITE: You say that "No one authorized
22 by the College has ever used these tactics". Has anyone
23 in the College done this without authority of the
24 College?

25 MR. MOISLEY: No, sir.

26 THE CHAIRMAN: You are leading into the
27 question if they have exceeded their authority.

28 MR. MOISLEY: They wouldn't be employed
29 if they did.

30 MR. WHITE: Who pays the expenses of the



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3 MR. MOISLEY: The pharmacists of Ontario.

4 MR. WHITE: The registration fees?

5 MR. MOISLEY: Yes.

6 MR. WHITE: May I ask what those fees are?

7 MR. MOISLEY: \$30, \$10 of which is remitted
8 to the main Pharmaceutical Association for membership
9 in that Association, leaving \$20 for the use of the
10 College. There is a further \$10 registration fee for
11 managers.

12 MR. WHITE: So you would have an income
13 of about \$30,000?

14 MR. MOISLEY: Yes.

15 MR. WHITE: Does the College request or
16 require its members to charge certain prices for their
17 drugs?

18 MR. MOISLEY: No, sir.

19 MR. WHITE: Does the College recommend
20 certain price schedules?

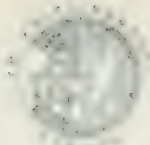
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23 MR. WHITE: Does the College recommend
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25 MR. MOISLEY: Yes, a professional fee.

26 MR. WHITE: You say there are fewer new
27 members, and on a per capita basis in this Province
28 your membership would be very much less than it was
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1 MR. WHITE: Are the members of your
2 Association, that is of practising pharmacists, required
3 by the College to keep financial records?
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5 MR. MOISLEY: Not by the College.

6 MR. WHITE: That is all, thank you.

2 7 MR. WHITNEY: Would you tell me what proce-
8 dure do you follow when you get a complaint of improper
9 practice by a pharmacist?

10 MR. MOISLEY: It is turned over to the
11 inspection department, of which Mr. Greenfield is chief.

12 MR. WHITNEY: You imply in your brief here
13 that you don't employ any secrecy in your investigation.
14 What do you do? Advise the pharmacist?

15 MR. MOISLEY: It all depends on the
16 complaint. There is an inspection made, the complaint
17 is run down, as it were.

18 MR. WHITNEY: You speak of the wholesalers
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20 MR. MOISLEY: Only a registered pharmacist
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2 MR. WHITNEY: Taking a hypothetical case
3 where a wholesale is also a licensed pharmacist,
4 can he sell the prescription directly?

5 MR. MOISLEY: He couldn't in my
6 estimation. That would certainly be a question for
7 our legal department.

8 MR. WHITNEY: How would you consider it
9 unethical?

10 THE CHAIRMAN: Do manufacturers sell to
11 their own employees, do you know anything about that?

12 MR. MOISLEY: I have heard such rumours,
13 sir.

14 THE CHAIRMAN: I suppose the manufacturer,
15 if this is true, it would be in the same fashion as
16 the manufacturer of toasters who says to his employees
17 when you need a toaster you can get one at the certain
18 price because you work for me?

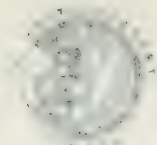
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20 MR. BRYDEN: What would be unethical
21 about a registered pharmacist in a wholesale manu-
22 facturing establishment dispensing prescriptions?

23 MR. MOISLEY: If I might, sir, would
24 you ask Mr. Greenfield that. He is the chief of the
25 inspection service. He is better qualified to answer
26 that than I am.

27 THE CHAIRMAN: How would the complaints
28 arise? What would they be about?

29 MR. MOISLEY: It could be about many
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other pharmacists.

THE CHAIRMAN: Could you give us the type of complaints that might come from other druggists?

MR. MOISLEY: Here again, may I refer that question to Mr. Greenfield? He handles that.

THE CHAIRMAN: Would they come from the public with respect to prices charged?

MR. MOISLEY: Yes.

MR. WREN: Do physicians frequently complain?

MR. MOISLEY: Very little, I would say, most of the complaints go to their own College with which we have a liaison at the registrar levels, and then taken up in due course.

THE CHAIRMAN: Mr. Moisley, this may be somewhat out of order in the sense that the retail druggists are coming tomorrow to talk to the Committee, but there is what appears to be an established trend in retail merchandising towards the establishment of discount houses. Would you have any comment to make with respect to pharmacy, drug departments in those discount houses? I am trying to give you this area of operation?

MR. MOISLEY: Well, I don't think that is a fair question to a licensing, disciplining body but I am not involved with monetary matters, with trade and commerce, Mr. Chairman.

THE CHAIRMAN: I don't think it is necessarily an unfair question at all, Mr. Moisley.



OTHER MEMBERS:

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2 My question is does the College of Pharmacy have any
3 policy with respect to registered and licensed
4 pharmacists being employed in, shall we say, a discount
5 house?

6 MR. MOISLEY: We have no policy.

7 MR. BRYDEN: Are you through for the
8 moment, Mr. Chairman?

9 THE CHAIRMAN: Yes.

10 MR. BRYDEN: I believe there is a man,
11 Murray Rubin, I think his name is. You may not be
12 familiar with the matter.

13 MR. MOISLEY: Quite.

14 MR. BRYDEN: You are?

15 MR. MOISLEY: Yes.

16 MR. BRYDEN: He operates something in
17 the nature of a discount house on his own. I believe
18 he got into a certain amount of trouble with the
19 College some months ago.

20 MR. MOISLEY: Not for that reason.

21 MR. BRYDEN: What was the reason?

22 MR. MOISLEY: Because he was operating
23 a type of pharmacy with no equipment, no library and
24 very little stock.

25 MR. BRYDEN: Well, was he illegally
26 dispensing drugs?

27 MR. MOISLEY: No.

28 MR. BRYDEN: Well then, why was he in
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2 MR. MOISLEY: The Act, unfortunately,
3 does not lay that down as yet, but there is a clause
4 in the Act which refers to the premises and other
5 matters and in the opinion of Council he wasn't meeting
6 these requirements.

7 MR. BRYDEN: What action did the College
8 take in this matter?

9 MR. MOISLEY He was not permitted to
10 carry on a pharmacy at that location under the
11 circumstance in which he was operating on a second
12 floor location, with no water, limited accommodation,
13 one room, no fixtures, no equipment.

14 MR. BRYDEN: But he was not dispensing
15 directly to the public, that is to the street trade,
16 was he?

17 MR. MOISLEY: He would dispense to anyone.

18 MR. BRYDEN: But essentially his business
19 was a mail order style of business?

20 MR. MOISLEY: That is what he claims.
21 He would accept prescriptions from anybody.

22 MR. BRYDEN: Were there any charges?

23 MR. MOISLEY: Certainly.

24 MR. BRYDEN: Was he convicted or what
25 was the disposal of the charges?

26 MR. MOISLEY: As I told you before he
27 was not allowed to carry on at that location.

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1
2 licence wasn't suspended as a pharmacist.

3 MR. BRYDEN: I will be perfectly frank,
4 certainly a lot of people including myself, got the
5 impression that the action was taken against him
6 primarily because he was selling at lower prices than
7 the regular retail druggist.

8 MR. MOISLEY: I can tell you, sir, that
9 wasn't so.

10 MR. BRYDEN: He is, in fact, doing that
11 though, is he not? He sells, he advertises

12 MR. MOISLEY: He advertises that way.

13 MR. BRYDEN: He sells at the wholesale
14 price plus a certain dispensing fee, that is his
15 advertisement?

16 MR. MOISLEY: That is advertised.

17 MR. BRYDEN: Is there any objection to
18 that as far as the College is concerned?

19 MR. MOISLEY: We have no control over
20 prices as such, Mr. Bryden. As I made quite clear we
21 are a licensing and disciplining body only.

22 MR. BRYDEN: Therefore, as far as you
23 are concerned, you would be neutral with regard to
24 any advertising.

25 MR. WHITE: Wasn't his licence ...

26 MR. MOISLEY: No.

27 MR. WHITE: Was his licence in jeopardy
28 in some way?

29 MR. WREN: Was it suspended?

30 MR. MOISLEY: No, it wasn't suspended.



licence wasn't suspended as a pharmacist.

MR. BRYDEN: I will be perfectly frank,

certainly a lot of people including myself, got the

impression that the action was taken against him

primarily because he was selling at lower prices than

the regular retail druggist.

MR. MOISLEY: I can tell you, sir, that

wasn't so.

MR. BRYDEN: He is, in fact, doing that

though, is he not? He sells, he advertises

MR. MOISLEY: He advertises that way.

MR. BRYDEN: He sells at the wholesale

price plus a certain dispensing fee, that is his

advertisement?

MR. MOISLEY: That is advertised.

MR. BRYDEN: Is there any objection to

that as far as the College is concerned?

MR. MOISLEY: We have no control over

prices as such, Mr. Bryden. As I made quite clear we

are a licensing and disciplining body only.

MR. BRYDEN: Therefore, as far as you

are concerned, you would be neutral with regard to

any advertising.

MR. WHITE: Wasn't his licence ...

MR. MOISLEY: No.

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in some way?

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3 have the clipping in front of me, I am relying on
4 memory, but there was at the time a suggestion although
5 his licence as a pharmacist was not in jeopardy his
6 licence to operate an establishment was in jeopardy,
7 but I understood you to say a few minutes ago you
8 don't license premises, you just license pharmacists.

9 MR. MOISLEY: These pharmacists must be
10 licensed at that location in order to obtain their
11 products, drugs.

12 MR. WREN: Is a standard laid down for
13 the premises?

14 MR. MOISLEY: No, as I said before there
15 is none as such.

16 MR. WREN: How could you discipline him
17 for certain defects in his equipment if you don't
18 state them?

19 MR. MOISLEY: Because he wasn't properly,
20 conducting a proper pharmacy.

21 MR. BRYDEN: If he was operating within
22 the law...

23 THE CHAIRMAN: I would think we are not
24 concerned entirely with the provisions of The Pharmacy
25 Act. I do not see how a drug store could operate
26 without the supply of water and I am very much impressed
27 by that statement. I think that a body charged with
28 administering the responsibilities which are given
29 you under the Act should certainly endeavour to take
30 such matters into account. That must be reasonable,



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such matters into account. That must be reasonable.



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2 Mr. Bryden, would you not think?
3 MR. BRYDEN: Well, of course, we haven't
4 got the full report on the nature of the premises.
5 Has he moved?
6 MR. MOISLEY: No, he is in the same
7 premises.
8 MR. BRYDEN: Are the premises now
9 considered satisfactory?
10 MR. MOISLEY: That I would prefer not to
11 answer. The case is still under inspection, may I put
12 it that way.
13 MR. TROTTER: I had the idea that the
14 College actually did have control of prices. I saw
15 another instance in the paper -- I admit I got this
16 information from the paper that the drug store, the
17 pharmacy that is now Honest Ed's, I think the College
18 took action against them in that case.
19 MR. MOISLEY: Mr. Chairman, what do I
20 have to do to make these gentlemen understand we are
21 a licensing and disciplining body only. Do they take
22 newspapers as authority or do they take my statement?
23 THE CHAIRMAN: Mr. Moisley, I think you
24 have to understand the nature of this Committee and
25 the members who make it up. Your duty is to answer
26 the questions as best you can.
27 MR. MOISLEY: All right.

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MR. MOLISEY: All right.



1 We will hope that they don't make you
2 repeat yourself too often. It might be that maybe the
3 other witness, I don't know, has more direct information.
4

5 MR. MOISLEY: I can give you the informa-
6 tion on this if the gentleman wishes it. Your concern
7 is with the Honest Ed situation is it?

8 MR. TROTTER: That is right, yes.

9 MR. MOISLEY: Norman Englander who is the
10 pharmacist in the case failed in business on Queen West.
11 He applied to the College to move his pharmacy. That
12 is, the location of his pharmacy to Honest Ed's. It was
13 refused. It was merely the move in location and council
14 did not think that Honest Ed's store was a fitting loca-
15 tion for a pharmacy. That, in brief, is the sum and
16 substance of it. There was no price involved.

17 MR. TROTTER: Wouldn't the price be the
18 main thought there because I understand that prices are
19 a lot lower at that place?

20 MR. MOISLEY: We are getting back to
21 something again which I have no authority on whatever.

22 THE CHAIRMAN: Just a minute, there is
23 no reason for us to question this witness or his bona
24 fides Mr. Trotter. He has said that he is the registrar
25 of the College of Pharmacy and he has said that price
26 was not a factor in any steps which the College took.

27 MR. WREN: Yes, but Mr. Chairman, with
28 respect are they not making some attempt here to control
29 prices by controlling location? In other words, what
30 would be wrong with locating in Honest Al's or Honest



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MR. WRAN: Yes, but Mr. Chairman, with

respect are they not asking some questions here in regard

prices by controlling locations? In other words, what

would be wrong with locating in Honest Al's or Honest



1 Ed's or anywhere else providing the premises occupied
2 by the pharmacist were suitable for the duties he was
3 to perform? What difference does the location make sir?
4

5 MR. MOISLEY: That is something, Mr.
6 Wren, which must be decided by our council.

7 MR. WREN: I think indirectly you are
8 getting at price.

9 MR. TROTTER: Not indirectly, directly.

10 MR. MOISLEY: You can think what you wish.

11 MR. PRICE: Mr. Chairman, I believe Eaton's
12 had a pharmacy in their store.

13 THE CHAIRMAN: The T. Eaton Company?

14 MR. PRICE: The T. Eaton Company, yes.
15 This would seem to me to be somewhat similar department
16 store type. What should be the objection? I can't see
17 what the objection would be. This is a very large,
18 reputable organization. I can't see what would be
19 wrong with the premises there. I have been in the
20 premises. I can't see that it would be very much
21 different. It's an Eaton's operation on a smaller scale.
22 I am not asking the witness to answer the question.
23 He has told us that he did not necessarily make the
24 decision. I personally can't see that it would make
25 very much difference whether it is Eaton's or Honest
26 Ed's.

27 MR. MOISLEY: I can say sir, for your
28 information, that the T. Eaton Company was in business
29 before the present Pharmacy Act was written and permitted
30 to carry on, as such. Simpson's and Eaton's both. If



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1 that is any help.

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3 MR. WHITE: Mr. Chairman, there is a
4 letter here in the Star of May 17th which contends - it
5 is written by someone claiming to be a druggist - and
6 he claims that the inspection made by the Ontario
7 College of Pharmacy inspector includes checking of their
8 price of prescriptions and if they fall short of the
9 set price schedule, he contends they are threatened
10 with the breach of the Code of Ethics and subsequent
11 appearance before the College Council. Would you comment
12 on that Mr. Moisley?

13 MR. MOISLEY: Would you indicate how the
14 letter is signed sir?

15 MR. WHITE: Signed "Druggist".

16 MR. MOISLEY: Yes. In your opinion would
17 he be a professional person?

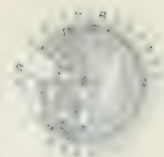
18 MR. WHITE: I don't know. I am asking
19 you to comment on the letter.

20 MR. MOISLEY: To comment on the letter.
21 There is nothing in fact contained in that letter.

22 MR. WHITE: The very fact, Mr. Chairman,
23 that the College suggests a certain schedule of prices
24 is an indication that they might attempt to police that
25 schedule and I think that is what the members are
26 trying to determine today.

27 MR. MOISLEY: I have already said Mr.
28 White that we do.

29 MR. BRYDEN: What is the purpose of your
30 guide on prices, or whatever it is you call it?



that is my help.

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guide on prices, or whatever it is you call it?



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2 MR. MOISLEY: Just exactly what it says,
3 Mr. Bryden. It is a guide.

4 MR. BRYDEN: Aren't these pharmacists -
5 they are educated men - aren't they competent to work
6 out a businesslike price?

7 MR. MOISLEY: Granted. Possibly they are
8 but some are not. We have pharmacists in practice who
9 have graduated away back in 1916 and 1918. Possibly a
10 few before that, and with modern medication the way it
11 is, they are at a loss.

12 MR. BRYDEN: I have read in the Consumers'
13 Reports, a magazine put out by the Consumers' Union
14 that in the United States druggists have a code that
15 they put on the label of a prescription drug, which is
16 actually a series of letters if you look at it, but it
17 is an indication of price and if the same subscription
18 is taken to another pharmacist, he knows the price that
19 the previous druggist charged. Have you ever heard of
20 the practice of that kind in this country?

21 MR. MOISLEY: On the label?

22 MR. BRYDEN: Yes, on the prescription.

23 MR. MOISLEY: No. Let's make ourselves
24 clear. Are you referring to the label on the bottle?

25 MR. BRYDEN: I am asking you, the label
26 on the bottle and also with regard to the prescription.

27 MR. MOISLEY: Label on the bottle, no.
28 If the patient requests a copy of the prescription, a
29 notation in red may indicate as to price.

30 MR. BRYDEN: The price that this pharmacist

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3 MR. BRYDEN: Is it for the information
4 of another pharmacist?

5 MR. MOISLEY: It can, or any other manner
6 the pharmacist wishes to use it, yes.

7 MR. BRYDEN: Is there any other purpose
8 in putting this code reference on the prescription
9 than to advise the next pharmacist as to what the
10 price was the last man charged?

11 MR. MOISLEY: I would say no. That is
12 for his information.

13 MR. SUTTON: Mr. Moisley, I believe you
14 said that the pharmacist in both Eaton's and Simpson's
15 had been established before your organization was
16 established?

17 MR. MOISLEY: Before the present Act was
18 written sir.

19 MR. SUTTON: Well before the present Act
20 was written.

21 MR. MOISLEY: Yes.

22 MR. SUTTON: If a graduate pharmacist
23 applied now to establish a pharmacy in either Eaton's
24 or Simpson's would he be permitted to carry on?

25 MR. MOISLEY: Well now, just a minute,
26 until we get this question right. You mean if Eaton's
27 or Simpson's applied for a licence?

28 MR. SUTTON: I believe you just passed
29 the question off and said Eaton's and Simpson's
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4 MR. MOISLEY: Yes.

5 MR. SUTTON: In relation to your answering
6 the question on the request to establish the pharmacy
7 in Honest Ed's, it was pointed out similar establish-
8 ments were now in Eaton's and Simpson's and your answer
9 was that both Eaton's and Simpson's were established
10 before the Act.

11 MR. MOISLEY: Yes.

12 MR. SUTTON: Now if the Act, if a
13 registered pharmacist had applied to open a pharmacy
14 in either Eaton's or Simpson's would this application
15 be granted?

16 MR. MOISLEY: Pardon me for saying so,
17 I think this is a hypothetical question here because
18 Eaton's and Simpson's have their own pharmacy in their
19 branches.

20 MR. SUTTON: That is true.

21 THE CHAIRMAN: Well now Mr. Moisley the
22 situation here is this: let's take 'X' department
23 store that opens up tomorrow morning. You have explained
24 it, I gather this to be your answer, that Eaton's and
25 Simpson's were permitted to carry on because of what
26 are known as grandfather rights and the legislation
27 was not to be made retroactive. Now if department
28 store 'X' opened up tomorrow morning is this not your
29 question? Leave Honest Ed's out of it. If a modern
30 department store opened up tomorrow morning in the

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MR. MOISELY: Yes.

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4 the licence be granted? and (b): Is there any policy
5 referring to this matter in existence at the College of
6 Pharmacy? Now does that put the question?

7 MR. SUTTON: Yes.

8 MR. MOISLEY: It would be considered at
9 the present time by council.

10 THE CHAIRMAN: Just so we get this
11 straight, how do you spell council?

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E/AG/hm

2 MR. MOISLEY: C-O-U-N-C-I-L. The only
3 condition of it would be the pharmacist who was going
4 in that store, his business would have to be owned and
5 operated by him, paying rent possibly to the
6 department store or corporation, in which 51% of the
7 stock was common deferred.

8 THE CHAIRMAN: There are some regulations
9 or policies at the College whereby you will not issue
10 a practising certificate to a man who proposes doing
11 business in a store which is not owned by a practising
12 pharmacist. What would happen if I incorporated a
13 company and opened a drug store tomorrow?

14 MR. MOISLEY: I couldn't tell you.

15 THE CHAIRMAN: I am told there is a
16 policy, and the store itself on a partnership basis
17 has to be controlled by graduate pharmacists or the
18 majority of the common stock has to be owned by
19 graduate pharmists?

20 MR. MOISLEY: Yes, that is in the Act.

21 THE CHAIRMAN: So you are applying the
22 Act, and those sections of the Act were put in when?

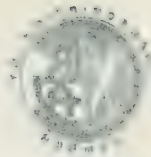
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24 THE CHAIRMAN: When was the Act first
25 promulgated?

26 MR. MOISLEY: 1870.

27 THE CHAIRMAN: Does it continue in that
28 form generally down through the years?

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THE CHAIRMAN: Were they major or minor?

MR. MOISLEY: I believe there was one major and several minor.

MR. TROTTER: Could you tell us about how many refusals are made per year of druggists who would like to transfer their store. For example, you say you have a policy that if you don't like the premises or the area to which the pharmacy is going, you refuse the transfer. About how many are refused a year?

MR. MOISLEY: Since I have come to the office, there has only been one.

MR. TROTTER: I understand the College, your governing body of the College, there are sixteen members, is that correct?

MR. MOISLEY: Yes.

MR. TROTTER: Of that sixteen, who on that decides if a transfer will be allowed, all sixteen?

MR. MOISLEY: The whole sixteen.

MR. WREN: In other professions, for example law, it is my impression it is not the college or licensing body that would set up a guide of fees, but the Bar Association?

THE CHAIRMAN: I can only speak for the legal profession, where the recommendation for the scale of costs comes from the local association, the county association.

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2 Dental Association also said they set the scale of
3 fees?

4 MR. WREN: Yes, but not the College of
5 Dental Surgeons.

6 MR. TROTTER: The sixteen members of
7 your Council, one I understand is the Dean of the
8 College. The other fifteen members are elected.
9 Do they all have drug stores or pharmacies of their
10 own?

11 MR. MOISLEY: Yes sir.

12 MR. TROTTER: All of them?

13 MR. MOISLEY: Yes sir.

14 MR. BOYER: Are they elected in various
15 parts of the Province?

16 MR. MOISLEY: By district. Representation
17 is by district.

18 MR. BOYER: And they have to come to
19 some central place for meetings to review these
20 applications?

21 MR. MOISLEY: That is correct.

22 MR. PRICE: How is that body chosen,
23 are they elected regularly, do they change?

24 MR. MOISLEY: Every two years.

25 MR. TROTTER: Suppose the Council refuses
26 to grant a transfer, the only appeal that the refused
27 pharmacist has is to the Courts?

28 MR. MOISLEY: Right.

29 THE CHAIRMAN: That would appear to be
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Your Council, one I understand is the Dean of the

MR. TROTTER: The sixteen members of

Dental Surgeons.

MR. WHEN: Yes, but not the College of

fees?

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1
2 MR. RICE: Next, Mr. Chairman and
3 members of the Committee, we have Mr. Thomas Greenfield,
4 who is the Chief Inspector of the Ontario College of
5 Pharmacy.

6 I understand you have a paper you wish
7 to deliver to the Committee?

8 MR. GREENFIELD: Yes I have.

9 THE CHAIRMAN: Would you identify
10 yourself with your full name?

11 MR. GREENFIELD: Yes, my full name is
12 Thomas E. E. Greenfield. I am the Chief Inspector of
13 the Ontario College of Pharmacy.

14 MR. RICE: How long have you been Chief
15 Inspector?

16 MR. GREENFIELD: Since 30th of December
17 1952.

18 MR. RICE: How long have you been
19 attached to the College of Pharmacy?

20 MR. GREENFIELD: Since that time.

21 MR. RICE: What did you do prior to
22 that time?

23 MR. GREENFIELD: I was practising
24 pharmacy in Toronto from 1947 until I took this
25 appointment. Prior to that I was a member of the
26 Royal Canadian Mounted Police in Toronto.

27 MR. RICE: Did you do any special work
28 with the Royal Canadian Mounted Police?

29 MR. GREENFIELD: Yes, I had charge of
30 the narcotic division of the Mounted Police in Toronto



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2 for some time, and I was on the Narcotics Squad here
3 for seven years.

4 MR. RICE: Did you attend the school
5 of Pharmacy after your Mounted Police service?

6 MR. GREENFIELD: No, I graduated in
7 pharmacy in 1923 before I joined the Police.

8 MR. RICE: What school of pharmacy did
9 you graduate from?

10 MR. GREENFIELD: The Ontario College on
11 Gerrard Street.

12 MR. RICE: What did you
13 do after you graduated from the Ontario College
14 School of Pharmacy?

15 MR. GREENFIELD: I practised pharmacy
16 until the end of 1925.

17 MR. RICE: How many inspectors have you
18 at the Ontario College of Pharmacy?

19 MR. GREENFIELD: At the end of 1960,
20 I was the only inspector, and in 1961, the first of
21 January, there were two appointed by the College
22 Council, and on March the first a third one, making
23 four in all at the present time.

24 MR. RICE: Would you proceed to present
25 your brief. Then perhaps we could ask you some
26 further questions.

27
28 SUBMISSION OF

29 THE ONTARIO COLLEGE OF PHARMACY

30 APPEARANCE: Thomas E.E. Greenfield, Chief Inspector
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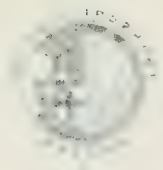
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14 inspectors. In March a third inspector was appointed.
15 There are thus four of us carrying out the inspection
16 work required.

17 At the present time there are 3877
18 registered pharmacists in Ontario, of whom 3359 are
19 engaged in retail pharmacy. There are 1946 pharmacies
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21 For clarification, it should first be
22 pointed out to the Committee that the Ontario College
23 of Pharmacy is the licensing and disciplining body
24 of Ontario's pharmacists and has not been a "college"
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2 to protect the people of Ontario against possible
3 malpractice and infractions of legislation affecting
4 the distribution of drugs and poisons to the public.

5 On my appointment I was instructed to
6 institute an educational program by visiting
7 pharmacists in their premises and pointing out the
8 requirements of the various Acts and Regulations which
9 govern them. The intention of this program was to
10 prevent infractions and thereby more effectively
11 safeguard the health of the people of this Province.

12 I would like to emphasize that checking
13 and reporting on prescription prices is not one of
14 the functions of the inspection staff of the College.
15 Neither I nor my three inspectors have any authority
16 with regard to pricing of prescriptions.

17 However, in anticipation of the interest
18 of the Committee in prescription prices, the Ontario
19 College of Pharmacy believes it would be helpful to
20 members of the Committee if I tabled at this time a
21 copy of "A Method of Estimating Professional Dispensing
22 Fees". This was published by the Ontario College of
23 Pharmacy in November 1958 and revised in January 1960.

24 This is a suggested schedule only. It is
25 a guide and not a requirement. The College, at the request
26 of its members, prepares this list as a help to
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5 services of the College with which I am familiar, I
6 would refer the Committee to the Council of the
7 College for information regarding suggested fee
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10 The seven principle Acts which affect
11 pharmacists and with which we are concerned are:

12 THE PHARMACY ACT:

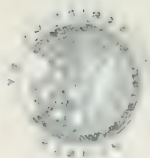
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- 19 1. The maintenance of personal super-
20 vision by registered pharmacists;

21 That is, it has to do that I ensure
22 that prescriptions in pharmacies are dispensed by
23 pharmacists, and not by unregistered help. That is
24 a very important safeguard for the public, to see that
25 they get the proper attention.

- 26 2. Cleanliness and modernization;

27 With our recent improvement in building
28 materials and bringing the interior of these shops
29 up to date, I have urged that these new materials be
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2 and in the modernization of our stores.

3 In cases where I have found unsanitary
4 conditions, they have been reported to the Council.

5 3. The maintenance of proper prescription
6 records;

7 A pharmacist must file a prescription
8 for every drug he dispenses on prescription. There
9 are some of them that have more work to it than just
10 filing the prescriptions. Records have to be kept,
11 particularly with barbiturates, which are a problem
12 today. These may not be repeated without the authority
13 of a physician. They are dangerous. They are covered
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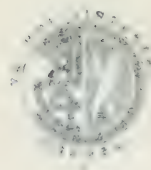


Just as an instance, cyanide, which is a very, very dangerous poison, and phenol, which used to be common, are almost passe in Ontario pharmacies today. They are two very, very dangerous drugs, and the pharmacists no longer carry them so that nobody gets them and cannot be harmed by them. In a good many cases new drugs have replaced these drugs and do the job they did. You will appreciate that insulin is dated, it has an expiry date and it is potent up to that date. Beyond that it weakens and the patient is not getting the effective medication that he is expecting to get. I have urged the pharmacists to instal refrigerators in their pharmacies, and I think this has been done in a great many, almost all, pharmacies in Ontario. I had one instance of finding a patent medicine in Hawkesbury, and while it was still in date it was only 32 units by analysis when it was supposed to be 40, and the authorities were quite concerned until I explained that this had been due to improper storage. So even in places like that who should not have those drugs we are still protecting the health of the people.

6. The answering of questions having to do with new drugs, new equipment and changes in legislation. We are trying to keep our pharmacies informed about new legislation, federal, provincial, etc., so that they are on the right side of the law.

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The Opium and Narcotic Drug Act

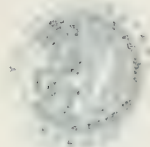
For instance, when a pharmacy ceases to exist as such, the narcotics have to be held in custody until sold to a licensee. The routine inspection in this case is the responsibility of the Division of Narcotic Control of the Department of National Health and Welfare, and their inspectors keep the records of pharmacists, as well as retailers and wholesalers.

The Excise Act

The brief item in this is the control of the sale of methyl hydrate, as far as labelling and selling on signature only are concerned. There was a sad poisoning through methyl hydrate going out of a pharmacy without bearing a label. The pharmacist was prosecuted under the Act with neglect. One man died.

The Proprietary and Patent Medicine Act

As the Committee may know, there has been a marked increase in patent medicine stores and the sale of patent medicines by variety and similar outlets. Having regard to the large number of new drugs available to the public, there is understandably some confusion



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4 tion staff to constantly check these outlets to see that
5 there has been compliance with this Act for the protec-
6 tion of the public.

7 Now, some years ago when I first started
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9 stores, not in one instance but in several.

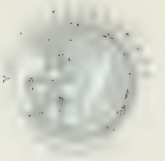
10 THE CHAIRMAN: Was it under regulation
11 and control at that time?

12 MR. GREENFIELD: Yes.

13 THE CHAIRMAN: How would they secure it?

14 MR. GREENFIELD: I took action against
15 the wholesaler who supplied it. I believe the small
16 store was not responsible. He asked for something and
17 the wholesaler sold it to him, and he being a pharma-
18 ceutical house, he was prosecuted in court, and that
19 stopped it.

20 While I am on this proprietary and patent
21 medicines, we had a very sad occurrence in Cobalt this
22 winter. A young child got a hold of a bottle of cold
23 tablets and he took about 40 of them. The child died
24 very suddenly. Now, the responsibility of issuing a
25 proprietary and patent medicine is that of the Federal
26 Government in Ottawa, and in this particular one, it
27 contained five items and each one of those items was
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2 The Pest Controls Act

3 The information is given to pharmacists
4 concerning poisonous substances under this Act.

5 The Feeding Stuffs Act

6 We supply information to pharmacists in
7 rural areas concerning substances under this Act.

8 During the year 1960, sixty charges were
9 laid under the various Acts with the following results:

10 There were - 21 convictions;

11 20 charges were withdrawn;

12 there were 10 dismissals;

13 5 cases were presented to the Discipline

14 Committee of the College;

15 2 inquests were attended, at which I gave
16 evidence;

17 2 cases of forgery were investigated and
18 evidence given in court, under the Criminal
19 Code, resulting in convictions.

20 There was a conviction which was dismissed,
21 while eight appeals from convictions were sustained.

22 Co-operation and assistance have been
23 offered to other enforcement bodies. In most of these
24 cases, technicalities involving pharmaceutical matters
25 were concerned.

26 Other bodies to whom assistance has been
27 given are:

28 Police forces in coroners' inquests (one
29 was Sudbury, one was Woodstock and one was Cobalt);

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3 These cases are reported to the Supervisor of Driver
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5 THE CHAIRMAN: When you are talking about
6 the use of drugs, you are talking about what branch?

7 MR. GREENFIELD: The so-called pep pills
8 and goofballs, barbiturates.

9 The Royal Canadian Mounted Police in
10 narcotic work.

11 Municipal police in cases of forged
12 prescriptions for barbiturates and amphetamines. The
13 first is the goofballs and the second is the pep pills.
14 There were six such cases up to April 15th of this year
15 and in that week five more offences were reported by
16 pharmacists. Additional cases are being reported every
17 week.

18 Reports have been made to the Director
19 of Driver Control, Department of Transport, and to the
20 Minister of Health for Ontario of instances where
21 unusually large quantities of habituating drugs have
22 been obtained by some individual.

23 Reference was made earlier to the appoint-
24 ment of additional inspectors this year. Council
25 deemed this step necessary because of the increased use
26 of stimulants and tranquilizers, the desirability of
27 more frequent contact with the practising pharmacist
28 for education and inspection, and generally to insure
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2 Ethics of the Ontario College of Pharmacy. I have here
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4 The inspection service was carried out
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7 community as a citizen and as a professional person,
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9 I have endeavoured to show that the
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15 cost of this four-man inspection service is borne by
16 the pharmacists of this Province and that not one penny
17 for this purpose comes out of the treasury of the Provin-
18 cial Government.

19 Thank you, gentlemen.

20 MR. WREN: You speak of these 60 charges
21 being laid. Were they laid by your staff or by the
22 various police forces?

23 MR. GREENFIELD: By myself.

24 MR. RICE: Dealing first of all with
25 your inspection service, having regard to items you
26 have indicated, under your jurisdiction, have you
27 adequate staff in these four men, have you adequate
28 control in Ontario in this regard?

29 MR. GREENFIELD: I think we have now.

30 MR. RICE: Is there any qualification



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THE CHAIRMAN:

MR. WHEAT: You speak of these 60 charges

being laid. Were they laid by your staff or by the

various police forces?

MR. GREENFIELD: By myself.

MR. RICE: Dealing first of all with

your inspection service, having regard to items you

have indicated, under your jurisdiction, have you

adequate staff in these four men, have you adequate

control in Ontario in this regard?

MR. GREENFIELD: I would say that

MR. RICE: Is there any qualification



1
2 that you require for a member of your staff?

3 MR. GREENFIELD: Yes. These men are all
4 pharmacists. There are three of us who are Bachelors
5 of Pharmacy, and one is a Bachelor of Science in phar-
6 macy. I have done police work, and at the present time
7 these inspectors are undergoing training with the
8 Ontario Provincial Police College so they will be able
9 to carry on these duties.

10 MR. RICE: I notice here on page 4 you
11 refer to two cases of forgery. Is that the same type
12 of forgery you referred to earlier as forgery of pres-
13 criptions?

14 MR. GREENFIELD: Yes. Last year there
15 were two.

16 MR. RICE: Have you run into any forgery
17 in respect to counterfeit drugs, that is a drug manufac-
18 tured by someone who represents it to be something it
19 isn't?

20 MR. GREENFIELD: About five years ago I
21 did. An importation from the United States came in
22 here. These drugs were strictly counterfeit, and they
23 were heart-shaped pills, and within two or three weeks
24 they all showed up with white spots in them, and I had
25 them analyzed. I don't recall the percentage potency
26 they turned out to be, but they were very, very much
27 below what they were supposed to be.

28 MR. RICE: Could you explain which way
29 they were counterfeit or forgery?

30 MR. GREENFIELD: These were manufactured



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MR. GREENFIELD: These were manufactured



1 in a pharmaceutical place in the United States, and they
2 were a peculiar heart-shaped tablet, supposed to be
3 amphetamines. They even were made heart-shaped, but in
4 the dye, the counterfeit dye, there was a little nick
5 on the top of the heart that wasn't quite right that
6 disclosed that they were counterfeit. That was one
7 thing, and, of course, the potency was the other.



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2 MR. PRICE: Can you give us any idea
3 about where these pills were manufactured? Do you
4 recall the type of place where they were manufactured?

5 MR. GREENFIELD: No, I didn't at that time.
6 There has been publicity about that since, and I believe
7 this counterfeit place in the United States, there is
8 criminal action undertaken by the F.D.A. of the United
9 States Government right at the present time.

10 MR. PRICE: We heard yesterday they
11 wouldn't necessarily be inferior, they could be manufac-
12 tured under very good conditions and could be really as
13 good pills as they are imitating.

14 MR. GREENFIELD: This particular one was
15 outstanding.

16 MR. RICE: Have you any other cases of
17 counterfeit drugs of that nature?

18 MR. GREENFIELD: No, I haven't.

19 MR. RICE: Do you recall how these drugs
20 got into Ontario, was it retail, wholesale or what
21 level did they come in on?

22 MR. GREENFIELD: At the time they were
23 brought in by a salesman who visited here and gave them
24 to a friend. I found out about them very quickly. I
25 found he distributed them in four places. I had them
26 gathered up, and said put them on my table at my office
27 within a certain time or else I would have the Customs
28 look into the matter. They were there. They were
29 destroyed.

30 MR. PRICE: They didn't actually get into

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1
2 drugstore?

3 MR. GREENFIELD: Yes, they did.

4 MR. PRICE: It seems rather hard to
5 understand that a pharmacist would actually be a party
6 to buying counterfeit drugs simply on the basis, I
7 suppose, that he could get them cheaper and sell them
8 as imitations of a real product. I find it rather
9 difficult. Surely that must be against...

10 MR. GREENFIELD: It is, yes.

11 MR. PRICE: The Code of Ethics.

12 MR. GREENFIELD: This is about five or
13 six years ago, before we had the Code, as a matter of
14 fact.

15 MR. RICE: This man that distributed,
16 was he a wholesaler in business otherwise or was this
17 just one deal as far as he was concerned?

18 MR. GREENFIELD: They came in with this
19 salesman into Canada, in the back of his car. He sold
20 to his friend.

21 MR. RICE: And the friend was a drug
22 salesman also?

23 MR. GREENFIELD: Yes, this friend had too
24 many so he sold them to three other people and the
25 whole batch was gathered up and destroyed.

26 MR. SUTTON: This happened five years
27 ago. Has there been any recurrence of any such inci-
28 dent?

29 MR. GREENFIELD: I haven't had any recur-
30 rence of that. I only had one occasion.

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recurrence of that. I only had one occasion.



1
2 MR. WREN: Was the pharmacist barred?

3 MR. GREENFIELD: I beg your pardon?

4 MR. WREN: Was the pharmacist concerned
5 barred from practice?

6 MR. GREENFIELD: No, they weren't.

7 MR. WREN: They weren't.

8 MR. GREENFIELD: He was called before the
9 Committee of the Council and ordered to surrender these,
10 which he did, and he lost, probably, quite a few dollars
11 over that. At that time the penalty wouldn't have
12 been very much.

13 MR. RICE: Now, Mr. Greenfield, you
14 referred in your brief to prescription lists, these
15 are schedules to the Act?

16 MR. GREENFIELD: Yes.

17 MR. RICE: There is also a Dominion
18 prescription list that was given?

19 MR. GREENFIELD: That is right.

20 MR. RICE: Is there a duplicate list of
21 prescriptions that the chemist may get a drug on one
22 list that may not be on another list?

23 MR. GREENFIELD: That is correct. I
24 have the Federal list here. I do not have enough to
25 go around. That is the Federal list.

26 MR. BRYDEN: Is that an appendix to the
27 Food and Drug Act?

28 MR. GREENFIELD: That is in the Food and
29 Drug Regulations.

30 THE CHAIRMAN: Is this a list the retail



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Drug Act.
THE CHAIRMAN: Is this a list the retail



1
2 druggist has before him to know what items are included
3 and that he has to watch his dispensing over?

4 MR. GREENFIELD: That is right, sir, they
5 are, Mr. Chairman.

6 MR. RICE: Well, how does the druggist
7 keep his records with regard to this list, the Federal
8 list and the Provincial schedule?

9 MR. GREENFIELD: On the Federal he is
10 required to file the prescription for each sale, which
11 prescription must be filed, kept for at least two years.
12 Under the Pharmacy Act he is required to keep a record
13 of each sale. The prescription is the record, but he
14 is also required to keep a record of his purchases so
15 an audit can be made, and this is what the inspection
16 staff does in every store now. They make an audit of
17 these amphetamines and barbiturates to see there is no
18 traffic in them.

19 MR. RICE: Does he have to keep two
20 different books, one for the province and one for federal?

21 MR. GREENFIELD: No, the prescription on
22 file serves in both cases.

23 MR. RICE: Now, these prescription lists,
24 are they set out in generic names?

25 MR. GREENFIELD: Yes, some of them are.

26 MR. RICE: Are there any trade names used
27 in this list?

28 MR. GREENFIELD: Yes, there are. You
29 will notice after phendimetrazine and its salts there
30 is plegine. Phendimetrazine is the generic name and



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1
2 plegine is the trade name. Pheniprazine and its salts
3 and catron - that is the trade name. Marplan, librium -
4 trade names.

5 MR. RICE: In each case a generic name
6 is used - in each case where the trade name is used
7 the generic name is also used?

8 MR. GREENFIELD: That is right.

9 THE CHAIRMAN: So we can understand the
10 list, would sodium amytal be on the list?

11 MR. GREENFIELD: Sodium amytal is there
12 under the barbituric acid and its salts and derivatives.

13 MR. RICE: Now, Mr. Greenfield, in your
14 examination of the books and records, prescriptions and
15 so on would the prices that the druggists charge come
16 to your attention?

17 MR. GREENFIELD: Occasionally, yes.

18 MR. RICE: Is there any instruction or do
19 you give the druggist any instruction with regard to
20 prices if you notice they differ from what you normally
21 see?

22 MR. GREENFIELD: Yes, I have noted - I
23 have advised where a pharmacist was charging an exces-
24 sive price, I have reasoned with him about it. I have
25 also done it where he was charging, probably an elderly
26 man was charging a very low price, that is very, very
27 low so he was just probably breaking - not breaking
28 even, and I have even in some cases when someone has
29 said, well this is an old person, and this is a friend
30 of mine and he has dealt with me for years and he is



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2 not very well off and I have given him a special price -
3 I have said that is to be commended.

4 MR. BRYDEN: What is wrong with giving a
5 special price? If a fellow wants to go broke whose
6 business is it?

7 MR. GREENFIELD: That is right, it is his
8 business.

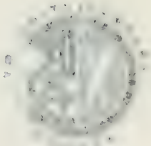
9 MR. BRYDEN: Why would you raise the
10 matter if you thought he was charging what was a rather
11 low price?

12 MR. GREENFIELD: He must make a profit
13 to keep his stuff up to date. That is one argument I
14 use. He must improve his premises and have them modern
15 and sanitary and all this, and he needed a profit to do
16 so.

17 MR. RICE: I note number 28 of this Code
18 of Professional Conduct, the pharmacist should not
19 deliberately under-price a prescription or a copy for
20 the purpose of injuring the reputation for fair dealing
21 of other pharmacists. Do you look at the price at all
22 in connection with that provision in the Code of Ethics?

23 MR. GREENFIELD: That might come in to
24 me as a complaint from a pharmacist who was injured.
25 That was previously gone over, about notes on prescrip-
26 tions, on a copy of a prescription, and that has been
27 discontinued to some extent in some quarters. Someone
28 wanted to get a little more business from a customer
29 and would cut them.

30 MR. BRYDEN: But it turned out to be an



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1 instrument of price cutting rather than maintenance?

2 MR. GREENFIELD: That is right.

3 MR. BRYDEN: Is that the only reason it
4 was discontinued?

5 MR. GREENFIELD: No, it was felt it might
6 be objectionable, legally.

7 MR. RICE: That then brings us into this
8 other matter of pricing; that is the big table, method
9 of estimating professional dispensing fees. Could you
10 explain to the Chairman and the members of the Committee
11 how this schedule works or this method?

12 MR. GREENFIELD: Each one of these would
13 have to be explained separately, but supposing we take
14 the eye drop on page 4. The fee is \$1.50 for one-quarter
15 ounce, the same for half-an-ounce and the same for one
16 ounce. Now in compounding the eye drops, the drugs
17 and packaging times two plus the fee, which is the
18 selling price, but there is a minimum price set at the
19 bottom. Now, you must appreciate in an eye drop there
20 is quite a considerable technical ability goes into the
21 preparation of an eye drop. First it must be sterilized,
22 the container must be sterilized. Everything that goes
23 into the eye drop requires sterilization, which takes
24 time. That may be the reason for the fee being quite
25 high because the pharmacist's time is also in the
26 dispensing fee. As the pharmacist remarks you have
27 only got one eye to lose, therefore he is quite careful
28 when he is preparing an eye drop. I would say it takes
29 probably half-an-hour of his time completely to prepare
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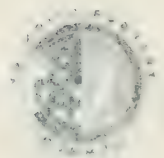
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2 an eye drop. When his rate is one and one quarter for
3 a forty-hour week - you will appreciate he is a hired
4 man. He is not earning wages at that rate.

5 MR. PRICE: What special precautions
6 would be taken to sterilize the ingredients?

7 MR. GREENFIELD: He would probably make
8 it up and put it in an autoclave or a pressure cooker
9 for 15 minutes. It takes time to bring that up to
10 pressure and time to carry off. That is where the
11 time is. It is practise. It is skill.

12 MR. RICE: Mr. Greenfield in the operation
13 of this method here could it be said that method contem-
14 plates two different, two classes of prescriptions?

15 MR. GREENFIELD: Yes.
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MR. RICE: First, those that are compounded by the pharmacists, and secondly, those that are not compounded by the pharmacists, is that correct?

MR. GREENFIELD: That is correct.

MR. RICE: And those that are compounded by the pharmacists the prescription fee, or the fee as is set out in the top of page 4 there where he takes the cost of the drugs at the rate of the smallest unit and he adds to that the cost of the container and then he multiplies that by two and then to that total he adds the suggested service fee which is down below here in the various parts. Is that the way it operates?

MR. GREENFIELD: Yes.

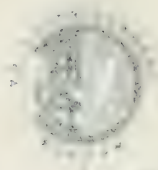
MR. RICE: And then for those that are not compounded by the pharmacist, he starts off with his fee and then he takes his drugs in the package. Now there he takes the drugs as in the unit that he buys them of one hundred and he goes over these various prices here and takes out the number that he is going to fill his prescription with and that is the price he goes by then, is it?

MR. GREENFIELD: That is right.

MR. RICE: And then he adds to that his package and multiplies that by two and then he gets his selling price.

MR. GREENFIELD: Which one is that you are referring to?

MR. RICE: I am just referring generally



MR. RICE: First, those that are

compounded by the pharmacist, and secondly, those that are not compounded by the pharmacist, is that correct?

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1
2 to the ones that are not compounded by the pharmacist.

3 MR. GREENFIELD: On page 6?

4 MR. RICE: No page at all; where he goes
5 over to page 6, 7, I understand they go down according
6 to price. On the lefthand side they are increased
7 is that not correct?

8 MR. GREENFIELD: Yes.

9 MR. RICE: That is by the hundred, and
10 then he goes across to the number he requires for
11 his particular prescription does he?

12 MR. GREENFIELD: That is right.

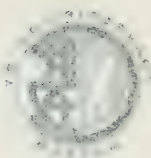
13 MR. RICE: And that is the price he gets
14 then for that type of ingredient and then he adds to
15 that the price of the package, multiplies it by two
16 and that is his selling price, providing it doesn't
17 go below the minimum total. The minimum there is the
18 minimum price in any event. Is that the way it
19 operates?

20 MR. GREENFIELD: Yes.

21 MR. RICE: Are there any questions the
22 members of the Committee want to ask on how that
23 schedule works?

24 MR. WREN: Yes. Just one question I have
25 there. It seems to me that this schedule is operated
26 in the manner where he first charges the fee, and then
27 he charges one hundred per cent on his drugs in
28 packages before he reaches the selling price is that
29 right?

30 MR. GREENFIELD: Yes, apparently. Or you



to the ones that are not compounded by the pharmacist.

MR. GREENFIELD: On page 6?

MR. RICE: No page at all; where he goes

over to page 6, I understand they go down according

to price. On the left-hand side they are increased

is that not correct?

MR. GREENFIELD: Yes.

MR. RICE: That is by the hundred, and

then he goes across to the number he requires for

his particular prescription does he?

MR. GREENFIELD: That is right.

MR. RICE: And that is the price he gets

then for that type of ingredient and then he adds to

that the price of the package, multiplies it by two

and that is his selling price, providing it doesn't

go below the minimum total. The minimum there is the

minimum price in any event. Is that the way it

operates?

MR. GREENFIELD: Yes.

MR. RICE: Are there any questions the

members of the Committee want to ask on how that

schedule works?

MR. WREN: Yes. Just one question I have

there. It seems to me that this schedule is operated

in the manner where he first charges the fee, and then

he charges one hundred per cent on his drugs in

packages before he reaches the selling price is that

right?

MR. GREENFIELD: Yes, absolutely.



1
2 must appreciate that eyedrops, generally speaking --

3 MR. WREN: It doesn't only apply to
4 eyedrops. It applies to the whole field here on
5 page 4.

6 MR. GREENFIELD: There would be his time,
7 weighing it out from raw ingredients; measuring.

8 MR. WREN: Isn't there some example, or
9 isn't there some allowance made, for example, on page
10 6 and 7 where he takes a good number of pills or
11 liquid from another container and it is broken down
12 here but there is a provision made for extra pricing.

13 MR. GREENFIELD: That wouldn't apply to
14 this, on page 4..

15 MR. WREN: Wouldn't that apply? Well
16 in effect he is charging a straight one hundred per
17 cent mark-up?

18 MR. GREENFIELD: That is right.

19 MR. WREN: Regardless, thank you.

20 THE CHAIRMAN: Well it all depends on
21 the volume of business wouldn't it? I mean one
22 prescription a day --

23 MR. WREN: He wouldn't be in business
24 with one prescription a day.

25 THE CHAIRMAN: I know, but I wanted to
26 make that point with you.

27 MR. RICE: Do you find --

28 THE CHAIRMAN: Before you go on, I wonder
29 if Mr. Greenfield could take some simple illustration
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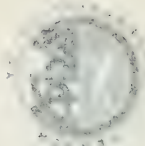


1
2 illustrate it to us how you would work up the fee,
3 by a specific example. Or take some kind of cough
4 medicine that you couldn't buy off the shelf and would
5 have to get a druggist to make it up and show how the
6 price would be developed.

7 MR. GREENFIELD: Well on the preparation,
8 for example homatropine, now that would be a very
9 small fraction of a grain per dose for the whole
10 mixture. Now then in compounding that he would make
11 a solution of a quantity where he could weigh one
12 grain and dilute it by calculation to the potency
13 required, or a gas. The doctor may prescribe that as
14 an antiseptic to go in with that.

15 He would have to weigh out his boric
16 acid which might be more than one grain so he would
17 weigh that out and add that to the mixture and then
18 there probably would be chlorambutanol as an antiseptic
19 and preserve it. Still that is not sterile so his
20 medicine bottle would be washed with distilled water.
21 The dropper bottle would be washed out with distilled
22 water together with the dropper and that, together with
23 his solution in the proper quantity will be put in
24 the autoclave or the pressure cooker and sterilized for
25 fifteen minutes at pressure and then it will be
26 cooled, mouth cooled and placed in the dropper bottle
27 and then into a carton, a sterile carton when it is
28 cool and the label typed and placed on that.

29 Now then the cost of the drugs, plus
30 the package; he is only charging for the quantity used.



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2 He has had to throw away probably ten times what he
3 actually used. So it is not all --

4 THE CHAIRMAN: Throw away or set aside?

5 MR. GREENFIELD: No, that wouldn't be
6 good. That particular item that I have mentioned would
7 deteriorate. There would be a mould growth get in it
8 and injure anyone else's eyes.

9 THE CHAIRMAN: What quantity package --
10 what do they do then with a product when it is opened
11 and can't be used again?

12 MR. GREENFIELD: On the eyedrop that
13 mounts up to a lot. They are careful that everyone is
14 individually manufactured, individually prepared .
15 Individually prepared so that you are not getting
16 something that was made up three weeks or a month ago.

17 MR. PRICE: It isn't a good idea then to
18 be using eye drops that somebody else has been using?

19 MR. GREENFIELD: No. Incidentally that
20 is one thing we have insisted on. That is, where
21 drugs are brought back for reason of not being used
22 they don't go out to anyone else. They might have been
23 in a home where there was an infection and that would
24 be unfair to the next customer so we have insisted that
25 they be not redispensed.

26 MR. WREN: All this process you have just
27 been discussing, no part of that is included in the
28 fee, in this schedule?

29 MR. GREENFIELD: The fee is the time
30 that he takes. About fifteen minutes to autoclave, to



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MR. GREENFIELD: That might amount to, in that particular prescription I imagine the drugs and package by two might amount to sixty cents so the price for that, if it was a half ounce, would be \$2.25.

MR. WREN: \$2.70.

MR. GREENFIELD: \$2.25.

MR. WREN: The cost of the drugs would be sixty cents?

MR. GREENFIELD: That is multiplied by twice.

MR. WREN: Be \$1.20.

MR. GREENFIELD: No, sixty cents; thirty cents.

THE CHAIRMAN: That would \$2.10 wouldn't it?

MR. GREENFIELD: Yes.

MR. RICE: Mr. Greenfield I understand that the manufacturers also supply a suggested sale price to the retail pharmacies do they not?

MR. GREENFIELD: That is on packaged -- yes, packaged.

MR. RICE: And that is the way they sell

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3 as a rule?

4 MR. GREENFIELD: Generally.

5 MR. RICE: Now in your inspection --

6 MR. GREENFIELD: It isn't always 40%.
7 With the distributor it's as low as 30% plus ten if
8 he pays his account on time.

9 MR. RICE: Do you think that pharmacies
10 are selling or dispensing according more to the sale
11 price suggested by the manufacturers or more according
12 to this method of estimating the prescriptions put
13 out by the College?

14 MR. GREENFIELD: I would say it varies
15 over the province. It varies from place to place in
16 the province. There is no hard and fast rule. They
17 don't go by this even (indicating blue book).

18 MR. RICE: Are there local groups in a
19 particular place, in particular cities, and so on,
20 that have developed their own method of calculating
21 the prescription price?

22 MR. GREENFIELD: Even that wouldn't be
23 uniform.

24 MR. RICE: But are there these areas where
25 they do have this tendency to develop --

26 MR. GREENFIELD: Yes, there are but they
27 are not uniform.

28 THE CHAIRMAN: In what amount of variation
29 would there be?

30 MR. GREENFIELD: Oh probably as much as



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2 25 and 30 per cent.

3 THE CHAIRMAN: At the retail level?

4 MR. GREENFIELD: Yes.

5 MR. RICE: I notice this has been revised
6 in January of 1960. Do you find that there is a trend
7 towards adopting this as the method of estimating
8 prescription price?

9 MR. GREENFIELD: It was very popular
10 for a while. I would say that there are so many
11 exceptions to it today that it isn't a standard. It
12 isn't a standard anymore.

13 MR. RICE: Do you get any complaints from
14 pharmacists that other pharmacists are not adhering
15 to a proper price?

16 MR. GREENFIELD: Yes, I do but I don't
17 pay any attention to them. That is not part of my job.

18 MR. RICE: That was the next question.
19 Is there anything you can do about it or do you attempt
20 to do anything about a complaint of that nature?

21 MR. GREENFIELD: No, I don't.

22 MR. RICE: Is there anyone attached to
23 the College, do you know, that has any jurisdiction
24 on any complaint of that nature?

25 MR. GREENFIELD: No, I don't think there
26 is, that deals with it.

27 MR. TROTTER: Mr. Greenfield I just
28 wanted to ask a question about the sale here and just
29 to use an example, turn to page 8, and going on to say
30 that \$10.00 for a hundred, that is what the list price

25 and 30 per cent.

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be and where I find that the druggists are criticized,
possibly unfairly, but they are criticized by people
of small means and using this figure of \$10.00 a hundred,
suppose we have an elderly person who has to take
fifty pills per month and on a small income and can
only buy a small amount at a time, if they buy ten
pills they pay \$2.40 is that correct?



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MR. GREENFIELD: That is according to this schedule, but in practise that is not what is followed out, because the pharmacist knows his customer, and if they can only afford that much. You see, I have noted under prescriptions, ten taken such and such a date. Ten a second time, ten a third time, and then at the end of the month, balance taken.

MR. TROTTER: Because if you were to follow that schedule, I hope the druggist knew that, because if a person had the money they could go in and buy fifty pills for \$6.50 and yet if in the course of a month they went in five times and bought ten pills each time, they would have to pay \$12.00 for the same number of pills, almost double the price.

MR. GREENFIELD: That is where the fee comes in, the pharmacist's wage. If he has to do the job ten times, there is ten times the time involved.

MR. TROTTER: Five times.

MR. GREENFIELD: And each time that fee is built in there. You will notice in the hundred, that there is no fee built in there. It gives him a straight list price.

MR. TROTTER: But in a larger centre, especially a city of this size does not a druggist prepare many of these pills at a time, at one time, and have them in bottles and containers?

MR. GREENFIELD: Each prescription is prepared individually, especially at that ten dollar

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2 rate. Those are so infrequent, those are the expensive
3 antibiotics, and they are infrequent prescriptions.
4 The average prescription price in Ontario is \$3.30.

5 MR. TROTTER: I rather question if a
6 lot of these are infrequent, and again I am thinking
7 of older people. There is quite a common demand for a
8 certain type of pills that are expensive, and that is
9 why I cannot understand that being a mass demand, they
10 wouldn't be much cheaper than they are, and I think
11 this points that up.

12 MR. GREENFIELD: The pharmacist cannot
13 give more than the doctor orders for one thing. He
14 is at the mercy of the doctor on a scheduled drug.

15 MR. TROTTER: But I have heard doctors
16 say before this group here that the doctors know the
17 pills are expensive and have to give a prescription
18 where they know their patient can only pay out a certain
19 amount at a time, so I think the patient is caught
20 in between.

21 MR. GREENFIELD: I have seen many times
22 on the prescription these notes, ten taken, and the
23 date, \$1.00 and then you go on to the end of the month,
24 then there would be fifty taken for a \$10.00 price.
25 The pharmacist has a heart. I have seen it too often
26 to think otherwise.

27 MR. WREN: Along those lines, dealing
28 with people of restricted means, I am going to ask
29 you a question I asked Mr. Moisley earlier. Would
30 you discipline a wholesaler who has proper pharmacist's

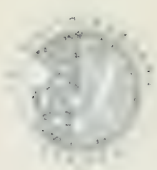
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2 qualifications, who issues on a doctor's prescription
3 drugs to a person who has limited means, and needs
4 assistance.

5 MR. GREENFIELD: He would be liable under
6 another law. That is: "Keep open shop". That is
7 section 38 of the Pharmacy Act. You see, he must be
8 licensed to keep open a pharmacy. If he is a
9 wholesaler and is not licensed as a retailer, then he
10 is breaching that section and another section too
11 that requires a licence for a shop.

12 MR. WREN: I have in mind as an example,
13 and I have given the secretary some information on
14 this. In this particular case there was a man who was
15 suffering from some chronic ailment, where he used
16 huge quantities of pills, and his bill was running
17 around \$600.00 to \$650.00 a year. He was a man in
18 seasonal occupation, who worked only eight or nine
19 months of the year, but had to have these drugs in order
20 to go to work at all. To make a long story short,
21 other agencies of the government made some effort to
22 try and obtain a supply for him on a doctor's
23 prescription at a lesser price. I don't know where
24 they tried to get these pills, and I was not interested
25 as long as they were safe and according to the doctor's
26 prescription, but someone, somewhere along the line,
27 lowered the boom on him, and I have two particular
28 instances, and both people are spending over \$600.00
29 a year on drugs, and it has just got to the point
30 where it is almost impossible to purchase them. What I



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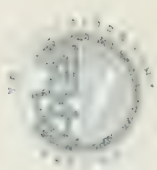
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6 MR. GREENFIELD: We have a problem with
7 wholesalers at the moment. You have probably read
8 about this recent legislation in Ottawa covering the
9 sale of scheduled drugs. Up until that came in, your
10 messenger boy could start up a wholesale drug house
11 without any competent help, and he didn't have to keep
12 any records whatever. That has been the bad situation,
13 because I know that these drugs have been getting out
14 to people who misuse them, and a man that would --
15 I can see the danger in it in this way, that there is
16 liable to be a -- keep on getting it and getting it
17 and getting it.

18 MR. WREN: I am speaking of instances
19 where it would be under control. What would be
20 wrong, in your opinion, with amendments to legislation,
21 if amendments were necessary, to provide for people
22 who are in those circumstances?

23 MR. GREENFIELD: Well, I cannot give an
24 answer to that because --

25 MR. WREN: Let me make my point. Pursuant
26 to a further -- other professions, for example the
27 legal profession and the medical profession, and some
28 others, where a person is in dire need of professional
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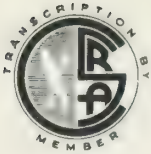
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4 any money. We get the situation where people of
5 limited means must have these drugs and despite the
6 best medical care, even though it is free, they are
7 unable to take advantage of the doctor's skill, because
8 they are unable to afford the drugs.

9 THE CHAIRMAN: It is my understanding
10 and experience they would make an effort to try and
11 help those situations.

12 MR. WREN: Through drug companies. The
13 witness though, suggests that that is illegal.

14 THE CHAIRMAN: No, a doctor can purchase
15 drugs on this list and buy them from the manufacturer
16 direct, and that goes back to the history of dispensing.
17 A doctor can dispense right in his office.

18 MR. WREN: In one of these instances,
19 that is the point I am getting to, the doctor issued
20 the necessary prescription, and I don't want to get
21 other government agencies in trouble. He said to a
22 certain officer of the government: "This is a
23 prescription and this man needs it and should have it",
24 and the process was interfered with, and he was told
25 this could not be supplied because it was a breach of
26 the Act. As a layman, all I am asking is why?

27 MR. GREENFIELD: I might explain that
28 your epileptics, the Provincial Legislature spends
29 thousands and thousands of dollars each year for
30 medication for them.



where any doctor has ever refused a person his best

medical skill by reason of the fact he didn't have

any money. We get the situation where people of

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2 MR. WREN: Are they not mostly teaching
3 hospitals?

4 MR. GREENFIELD: Yes, but they are paid
5 out of the legislative funds.

6 THE CHAIRMAN: They supply their patients
7 with the drugs on an out patient basis.

8 MR. GREENFIELD: Again in the city there
9 was some trouble here last fall about relief prescriptions.
10 I think \$60,000.00 was paid for a drug bill in
11 Metro Toronto. All I am pointing out is that there
12 are agencies that already do supply these expensive
13 drugs, or give it to a person who is epileptic. Some
14 are not expensive, but they are expensive to the
15 epileptic, because he hasn't probably much means of
16 support, but he gets them free from the government.

17 MR. BRYDEN: But there are lots of people
18 who require long treatment with expensive drugs, who
19 are not entitled to welfare aid. People with arthritis
20 for instance, who have a moderate income. There is
21 no provision for them.

22 MR. WREN: I am talking about people of
23 limited means, not the straight indigent.

24 MR. BRYDEN: May I return to the case
25 which I raised with Mr. Moisley. The case of this
26 man Rubin.

27 THE CHAIRMAN: Before you get into that,
28 let us make a note that Mr. Wren said we had some
29 information. We will have a look at this, to see if
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2 MR. BRYDEN: Getting back to the case
3 of this man Murray Rubin, who is in business with a
4 partner as registered pharmacists. I haven't met either
5 of the men, but I have an advertisement and I have
6 read about it. They claim that they cater to people
7 with chronic illnesses who are subject to very large
8 drug bills because of the constant repetition, and
9 that they, by cutting overhead and so on, can sell to
10 them at lower prices, and thereby save them money. On
11 the face of it, it appears to me that that is a
12 laudable objective. Does the College, or does the
13 inspection staff see anything wrong with that?

14 MR. GREENFIELD: I would say that, if
15 that is the case of the fact, that is laudable.

16 MR. BRYDEN: Again I come back to the
17 matter of Rubin getting into trouble with the College.
18 I imagine you know about it, because it was probably
19 your department that initiated the matter. Could you
20 outline to me the circumstances as you recall them,
21 or to the Committee, I am sorry?

22 MR. GREENFIELD: Well, I made an inspection
23 there and I might say that there were quite a few
24 enquiries over my telephone on my desk about this place
25 first.

26 MR. BRYDEN: From whom?

27 MR. GREENFIELD: The general public. I
28 cannot get them. When I call there, all I get is the
29 answering service.

30 THE CHAIRMAN: Which is the answering



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3 MR. GREENFIELD: This phone, Vanguard.
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5 called me and said that they had tried to phone at this
6 number, and all they could get was the answering
7 service. So I went to that place of business four times
8 at various times of the day. Reasonable times, between
9 nine o'clock and between five o'clock, and never could
10 gain access to it. I finally found that it was open
11 for one hour, between 9:30 and 10:30 each morning.

12 MR. BRYDEN: Well, is there anything
13 wrong with that?

14 MR. GREENFIELD: Nothing wrong with that,
15 only people weren't able to get information there on
16 their prescriptions. How can I get a copy of a
17 prescription that I sent there to have filled a month
18 ago, and now I want to take it to my own druggist?

19 MR. BRYDEN: But there was a telephone
20 answering service with which a message could be left,
21 so therefore they had a means of communicating with
22 the man?

23 MR. GREENFIELD: Yes, but if that
24 happened on Friday after 10:30 there was no one in
25 that office until 9:30 on Monday morning, and medicine
26 is something that people cannot do without at times.
27 That was the problem I saw in that. Another thing,
28 when I checked there, there was no facilities, no
29 balance, there wasn't even a pill counter. There
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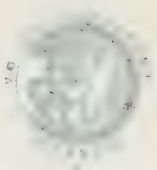
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2 MR. BRYDEN: Well, did it dispense an
3 ophthalmic prescription?

4 MR. GREENFIELD: Well, the purpose of
5 the pharmacy is to dispense prescriptions that are
6 brought there.

7 THE CHAIRMAN: Of any kind.

8 MR. GREENFIELD: You couldn't pick and
9 choose. You are not giving a service to the community.
10 As someone said here, you never heard of a case of a
11 doctor turning down a patient whether you had money or
12 not. But there was nothing there, a bare room with a
13 table and chair. There were eight items, half bottles
14 that he probably dispensed the rest of it.

15 MR. BRYDEN: Well, I understand he has an
16 office in an office building.

17 MR. GREENFIELD: No, it was a kitchen
18 apartment in an apartment, 24 steps.

19 MR. BRYDEN: Is it at 1179 St. Clair West?

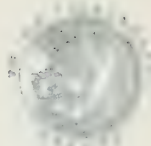
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21 MR. BRYDEN: What steps did you take with
22 regard to this man?

23 MR. GREENFIELD: Well, I checked the
24 records to see that he was keeping proper records, and
25 he wasn't.

26 MR. WREN: You say he wasn't?

27 MR. GREENFIELD: No, he wasn't. And the
28 place - there were no facilities for sanitation at all.
29 I asked him if he had any water and he said yes, he
30 would show it to me, and he took me out to the stairway



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3 didn't want to see it. The sanitation wasn't satisfac-
4 tory in my estimation. There were more samples on his
5 desk, in his store, than there were actual drugs.

6 MR. BRYDEN: What proceedings did you
7 take, if any?

8 MR. GREENFIELD: I referred it to the
9 Council.

10 MR. BRYDEN: And what happened after that?

11 MR. GREENFIELD: That would be up to the
12 Council to act on.

13 MR. BRYDEN: Do you know what action they
14 took?

15 MR. GREENFIELD: Mr. Moisley would be able
16 to explain that.

17 MR. BRYDEN: I am wondering, Mr. Chairman,
18 could we call in this man Rubin to see what he has to
19 say about it, because this is a case of a man advertising
20 on the basis of reduced prices and low overhead, and
21 I would like to know more about it. I would like to
22 hear what he has to say about it.

23 THE CHAIRMAN: I don't want him to get
24 the idea that we are encouraging any unsanitary opera-
25 tion of the drugstore. It is perfectly in order to
26 bring him along. Set a date.

27 MR. BRYDEN: Mr. Greenfield, as I under-
28 stand it, your function as an inspector is inherently
29 a disciplinary one.

30 MR. GREENFIELD: Yes, law enforcement.



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MR. BRYDEN: Do you think there is a possibility, when you discuss prices with people as a disciplinary officer or law enforcement officer, there is a certain pressure there, by the very fact that you discuss prices with them?

MR. GREENFIELD: No.

MR. BRYDEN: Why do you do it? What has it to do with law enforcement?

MR. GREENFIELD: I would have to discuss it on occasions, if someone complained about an excessive price.

MR. BRYDEN: Is there any law against excessive prices?

MR. GREENFIELD: No.

MR. BRYDEN: Is there any definition in the law as to excessive prices?

MR. GREENFIELD: No.

MR. BRYDEN: What has that got to do with law enforcement?

THE CHAIRMAN: I don't want to interrupt the answer or the line of answers, but I think when a complaint comes to a disciplinary body, whether the Dental Association or Medical or Legal, isn't there a duty on them to check into the information and apply such tests to see whether the complaint is justified. If they say it is not in the Act, they would say: "Don't hand me that line of argument. You are the public court of appeal".

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4 MR. GREENFIELD: I have complaints about
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6 did they get the right thing, and I would have to check
7 it.

8 MR. BRYDEN: You go and check to see if
9 they got the right thing, but not as to the price.

10 MR. GREENFIELD: No.

11 MR. BRYDEN: The title of this is "A
12 Statement on a Code of Professional Conduct (under Sec.
13 27(1)(c) of the Pharmacy Act, 1953)". I have that
14 section, and it says: "The council or disciplinary
15 committee appointed under a by-law passed by the council
16 may direct that the registration of any person can be
17 cancelled". And then (c): "If it finds that such a
18 person is found guilty of negligence or improper
19 conduct in a professional respect". It would appear to
20 me to give an impression that this is a code of conduct
21 sanctioned by the law in breach of which would result in
22 suspension of registration. Would that be a reasonable
23 assumption?

24 MR. GREENFIELD: I don't think that has
25 ever been tried.

26 MR. BRYDEN: Why is this reference made
27 to this section of the Act? It seems to me somewhat
28 intimidating. Perhaps you don't know.

29 MR. GREENFIELD: I don't know.

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3 there are three reference to price that I have noted,
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6 etc. There is also Section 3: "The pharmacist's fee
7 for professional services rendered should be fair and
8 equitable, commensurate with his professional knowledge
9 and skill in compounding and dispensing prescriptions
10 and rendering of other professional services".

11 Is there an implication there that it is
12 a violation of professional conduct to charge a price
13 that someone may consider to be not fair and equitable?

14 THE CHAIRMAN: Isn't there a phase of law
15 or legislation that, in the broad picture, if you are
16 selling your products to all of the public at "X" price
17 that would be all right, but the criticism lies where
18 you give an unduly low price to one member of the public
19 for the same product and charge another member, quantity
20 for quantity, quality for quality, a higher price?

21 MR. BRYDEN: I was under the impression,
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24 discretion as regards prices. But the College is essen-
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3 THE CHAIRMAN: This could be applied to
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7 up to a certain standard. It appears to me that the
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9 druggists on this level under the Act and it is an
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13 MR. BRYDEN: Is it considered unethical
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15 MR. GREENFIELD: No.

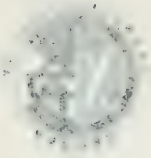
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24 MR. BRYDEN: Would this cover a situation
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5 MR. BRYDEN: Do you and your inspectors
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7 MR. GREENFIELD: No. It is a minor factor
8 in my job. As a matter of fact, I don't think it has
9 come up this year half-a-dozen or ten times, the matter
10 of prices. It is not a big factor in my job, not at all.

11 MR. TROTTER: You would be largely concerned
12 with the type of building they are using in a drugstore?

13 MR. GREENFIELD: The premises, yes.

14 MR. TROTTER: Is there a tendency today
15 for these building to become much larger?

16 MR. GREENFIELD: No.

17 MR. TROTTER: They are still as small?

18 MR. GREENFIELD: They like to see the
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Greenfield 1661

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MR. GREENFIELD: In a supermarket area
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MR. TROTTER: Then, doesn't the pharmacy
itself almost, in some cases, become a department store,
a small department store?

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MR. GREENFIELD: Yes, I regret to say it
does.

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MR. TROTTER: I think you said here in
the beginning of your talk there are 1,946 pharmacies
in Ontario, one less than in 1953?

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MR. GREENFIELD: That is correct.

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MR. TROTTER: Would the volume of business
have gone up in a very large percentage?

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MR. GREENFIELD: Oh yes, the prices for
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MR. TROTTER: So stores would be doing a
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MR. GREENFIELD: Yes, with the accompanying
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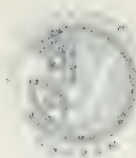
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I notice in the Code of Ethics, number 29 you seem to
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your College wished to start up in business, practise
his profession, isn't it extremely difficult for him to
start up, to do without help, outside help?

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MR. GREENFIELD: That is a difficult
question to answer because it would depend on his
operation. If he was operating, starting up one of



MR. GREENFIELD: In a supermarket area

the pharmacy will exist as an entity, yes.

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3 because the cost - the outlay of money would be extremely
4 high. If he was opening up a country drugstore in a
5 country town or small city I think probably three or
6 four years working for someone else would give him
7 enough capital to be able to start up such a business.

8 MR. TROTTER: As I understand it your
9 Code of Ethics frowns upon a young graduate forming a
10 company getting capital from someone who is not a
11 graduate?

12 MR. GREENFIELD: That is contrary to the
13 Pharmacy Act.

14 MR. TROTTER: But it is still possible to
15 form a company and have the majority of the men on the
16 Board of Directors graduates?

17 MR. GREENFIELD: Yes, and the majority
18 shares of each type of stock owned by pharmacists.
19 That is also a regulation of the Pharmacy Act.

20 MR. TROTTER: What type of agreement then
21 do you frown upon, private agreements that are not
22 brought to light?

23 MR. GREENFIELD: Yes.

24 MR. TROTTER: Where a man puts up the
25 capital and the graduate uses his name, is that what
26 you frown upon?

27 MR. GREENFIELD: Pharmacy is a profession
28 and there should be no dictation by some non-pharmacist
29 to a pharmacist, and there would be dictation if the
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MR. BRYDEN: How does a young lawyer?

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MR. TROTTER: A young lawyer doesn't have the capital, if I had to have the capital I would still be putting gas in.

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MR. GREENFIELD: The only thing I can answer to that question, the young men today, after three or four years, are getting into business on their own, a great many of them.

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THE CHAIRMAN: I don't understand this line of questioning. He could borrow money from the bank or a relative or father, there is no restriction against that, is there?

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MR. GREENFIELD: No.

MR. TROTTER: I am wondering, suppose a graduate does not have these facilities why he can't enter some agreement or get the capital from some other place?

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THE CHAIRMAN: That is right.

MR. TROTTER: I think that is why, according to the first part of your talk there is one less pharmacy in Ontario despite the growth of population - there is still less, there must be some reason.

MR. GREENFIELD: I don't think that is the reason, young fellows not being able to get into these places. I think the answer lies more in the



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2 fact there are wages of \$150 a week being offered to
3 pharmacists today - there are 50 openings for men of
4 that calibre at that rate, and that is much more of an
5 income than a young man would take in even after four
6 or five years in business.

7 MR. WHITNEY: Not lawyers, though.

8 MR. GREENFIELD: There is a big cry from
9 the north country for pharmacists.

10 MR. WREN: You have given me the impression
11 your College discourages pharmacists from locating in
12 department stores. What interests me is why do you not
13 discourage pharmacies from becoming department stores?

14 MR. GREENFIELD: We try.

15 MR. BRYDEN: You have been singularly
16 unsuccessful.

17 THE CHAIRMAN: Looking at the trend in
18 our city and urban shopping centres, if a young man,
19 taking Mr. Trotter's example or, in fact, any pharmacist
20 decided to go into business for himself in that shopping
21 centre, I think there are some facts that have not been
22 recorded and we perhaps ought to. He might go to the
23 owner of the shopping centre and say I want 750 or 500
24 square feet and I would like - I see one that looks
25 just about right that would suit me down at the corner.
26 The rental agent or the owner would say to him, well
27 that is all very fine but that is allocated in our
28 plan for such-and-such, this unit of 3,000 feet we have
29 allocated for the location, so, if the man is going to
30 go into business in the shopping centre and if he



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doesn't there probably will be someone else who is willing to, then he is going to get into the gift business and maybe a sandwich bar, cut glass and so on to make enough money to pay the rent. That is the economic experience I have seen.

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MR. GREENFIELD: There is an answer to that, Mr. Chairman. I understand for owners it is 6% rent, 6% of the turnover as rent.

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THE CHAIRMAN: 6% you are saying is the formula?

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MR. GREENFIELD: Yes, and all the economics our professors teach, the rent should not be more than 3% of the gross and that is probably getting a lot of the young fellows out of the supermarket-type stores.

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MR. WREN: Aside from property itself, what would you consider the minimum investment for a pharmacist today to go into a business, that is for equipment and stock?

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MR. WREN: Say 25,000.

MR. GREENFIELD: 25,000, if he had \$6,000 or \$8,000 in a town of 25,000 he could get started very easily, that is if his rent was reasonable.

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THE CHAIRMAN: You say six or eight thousand dollars, do you mean - would that be the total value of the capital, fixtures and the stock, or is that his equity in it?

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MR. GREENFIELD: His equity.



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2 THE CHAIRMAN: He would need \$6,000 to
3 \$8,000 to get a total investment of \$12,000, \$15,000 or
4 whatever it is.

5 MR. GREENFIELD: That is right, \$6,000
6 would be about 40%.



THE CHAIRMAN: He would need \$6,000 to

\$8,000 to get a total investment of \$12,000, \$15,000 or

REMARKS: 19-21

MR. GREENFIELD: That is right, \$6,000

would be about 4%.

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MR. RICE: Just to finish up my question, in your rounds do you find more prescriptions now being made of generic names or trade names? Is there a trend toward one or the other?

MR. GREENFIELD: In the City, yes, generic is used to some extent. In the country places, no. As a matter of fact, I don't see the generic -- when a doctor writes a prescription for a brand name the pharmacist must fill that, when he writes if for a generic name he may use a brand name, but outside the cities the pharmacist carries in fact normally one brand name of a drug.

MR. RICE: Do you find there is any trend towards one name or the other either in the city or the country? Is there a change coming about?

MR. GREENFIELD: There has been a change in the past two or three years.

MR. RICE: Which way?

MR. GREENFIELD: For the doctor to write the generic name, but they leave it up to the pharmacist to use what brand he considers appropriate.

THE CHAIRMAN: What affect would that have on the ultimate price of the prescription, if any?

MR. GREENFIELD: Economically the pharmacist would not have to carry five or six different brands to fill each generic name. It would have an affect on a pharmacist's overhead.

THE CHAIRMAN: What about on the retail

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price to the consumer?

MR. GREENFIELD: I don't think it would make much difference.

THE CHAIRMAN: It wouldn't make any difference.

MR. RICE: On this present arrangement you have referred us to, the price there is calculated to some extent on the purchase price to the pharmacist, so if he had to pay more money for a brand name than a generic name then he makes more money by selling the brand name than a generic name?

MR. GREENFIELD: It wouldn't be to any extent. It wouldn't amount to dollars.

MR. RICE: Thank you, any other questions?

MR. PRICE: Could Mr. Greenfield tell us about how many inspections were made in 1960?

MR. GREENFIELD: Unfortunately I would say not more than, actual visits, inspections, not more than 25 or 30 because I was tied up Police Court cases and other duties that took me all over the country.

MR. PRICE: When did staff increase?

MR. GREENFIELD: That is why the staff increased.

MR. PRICE: That is quite a recent increase in staff?

MR. GREENFIELD: Yes.

MR. PRICE: Then, in your opinion there should be more inspections?



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MR. GREENFIELD: No, I think the four of us can do a very excellent job.

MR. BRYDEN: How many have you managed to do this year since you got your staff?

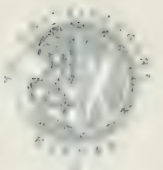
MR. GREENFIELD: Me?

MR. BRYDEN: Your staff?

MR. GREENFIELD: They have been doing training. I would say one has done seventeen or eighteen.

MR. BRYDEN: In how long a period?

MR. GREENFIELD: He has been out about three weeks steady. These forgeries take a lot of time when they come in. We understand other police forces haven't the technicians to check up forgery prescriptions. We have to do the checking for them and then turn it over to them. It means checking up the pharmacy's records for about six months back and probably 25 pharmacies in an area.



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L/MR/hm 1

2 Now one persons spreads their prescriptions from
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6 MR. PRICE: Mr. Chairman would there be
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8 and inspections made by the --

9 MR. GREENFIELD: The Mounted Police do
10 not inspect pharmacists anymore as they used to. That
11 is done by a pharmacist employed by the Narcotics
12 Division and there are three in the Province of Ontario.
13 They are answerable to the Chief Narcotics Division
14 in Ottawa. In Montreal I understand the Mounted Police
15 are enforcing the illicit traffic in goofballs and
16 pep pills. They haven't started here.

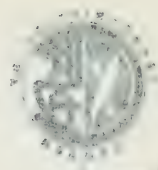
17 THE CHAIRMAN: Might it be speaking
18 accurately Mr. Greenfield that when we talk about
19 narcotics and these special narcotic agents that their
20 activities have to do with the general area of people
21 who have the drug habit, morphine, whatever the item
22 may be, as against -- which is a distinctly separate
23 category from the area of the subject of the drugs
24 we are talking about?

25 MR. GREENFIELD: That is right.

26 THE CHAIRMAN: So that you are the one
27 who is concerned with the area of drugs the Committee
28 is interested in?

29 MR. GREENFIELD: Very much so.

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Room number 2 on the main floor.

---Hearing adjourned at 5:05 p.m.



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Select Committee on Drugs

HEARINGS

HELD AT

PARLIAMENT BUILDINGS

TORONTO ONTARIO

VOLUME No.: DATE:

17

JUNE 7 1961

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Wednesday,
the 7th of June, 1961,
at 2 p.m.

COMMITTEE:

MR. H.L. ROWNTREE, Q.C. -- Chairman

MR. A. WREN

MR. J.A. FULLERTON

MR. J. TROTTER

MR. R.E. SUTTON

MR. R.J. BOYER

MR. N. WHITNEY

MR. H.J. PRICE

MR. K. BRYDEN

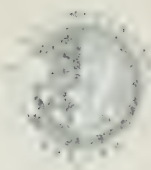
MR. J. WHITE

MR. G.F. LAVERGNE

MR. S.J. GADSBY, F.C.I.S., Secretary

MR. HAROLD A. RICE -- Committee Counsel

MR. W.J. AYERS -- Accounting
Consultant to the
Committee



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COMMITTEES:

MR. J. J. [illegible]

- MR. A. WREN
- MR. J. A. FULLERTON
- MR. J. J. [illegible]
- MR. R. E. SUTTON
- MR. R. J. BOYER
- MR. N. WHITBY
- MR. H. J. PRICE
- MR. E. [illegible]
- MR. J. WHITE
- MR. G. B. LAFRANCHE

MR. J. J. [illegible]

MR. HAROLD A. RICE
 Committee Counsel
 MR. J. J. [illegible]
 Committee for the
 [illegible]

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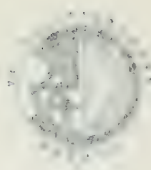
--- On resuming at 2 p.m.

THE CHAIRMAN: I will call this meeting to order.

In arranging the schedule for the hearings, tomorrow is left vacant, and it was in the Committee's mind that the retail pharmacists may well take two afternoons to present their material, and we want to give them ample scope for anything they have to say. There is a great deal of public interest on the part of not only the public but also of this Committee in what the retail druggist does, because the retail druggist from the start has been the friend of the average citizen who relies upon him not only for the efficient and reliable dispensing of prescriptions - and I am going back in my mind historically somewhat long before there was any such thing as a hospital scheme - not only for his drugs does he rely on them but the retail druggist occupies a major place in the community in the business life of any populated area.

Now, I would think there would be many points to be discussed and to be brought out. I haven't had the privilege of looking at this supplementary brief. I gather from the agenda which the Secretary has given me that there is the brief and there is the supplementary brief from the Ontario Retail Pharmacists' Association, and there are representative druggists here from Renfrew, London, Guelph and Toronto.

Now, Mr. Robertson.



--- On resuming at 2 p.m.

THE CHAIRMAN: I will call this meeting.

In arranging the schedule for the meeting,

tomorrow is left vacant, and it was in the Committee's mind that the retail pharmacists may well take two afternoons to present their material, and we want to give them ample scope for anything they have to say. There is a great deal of public interest on the part of not only the public but also of this Committee in what the retail druggist does, because the retail druggist from the start has been the friend of the average citizen who relies upon him not only for the efficient and reliable dispensing of prescriptions - and I am going back in my mind historically somewhat long before there was any such thing as a hospital scheme - not only for his drugs does he rely on them but the retail druggist occupies a major place in the community in the business life of any populated area.

Now, I would think there would be many points to be discussed and to be brought out. I haven't had the privilege of looking at this supplementary brief. I gather from the agenda which the Secretary has given me that there is the brief and there is the supplementary brief from the Ontario Retail Pharmacists' Association, and there are representative druggists here from Windsor, London, Guelph and Toronto.



1
2 MR. ROBERTSON: Yes sir.

3 THE CHAIRMAN: Are you appearing for this
4 group?

5 MR. ROBERTSON: Yes. I would like to
6 have Mr. Wilkinson, the first vice-president of the
7 Association and president-elect to present the Associa-
8 tion's brief, which is not long, following which he
9 will present a brief of his own business - he comes
10 from Windsor; he is not a big druggist - present his
11 own brief, following which we have some independent
12 druggists who will present their own particular private
13 views. I think that will be of assistance to you.

14 THE CHAIRMAN: The whole object, I take
15 it, is to put this picture in its perspective.

16 MR. ROBERTSON: Yes, from the point of
17 view of the retail druggist.

18 THE CHAIRMAN: By the way, there is a
19 Toronto retail organization, is there not? Are they
20 part of the Ontario?

21 MR. ROBERTSON: Oh, yes.

22 Mr. Wilkinson, I would like to present
23 you to Mr. Rowntree, the Chairman, and particularly to
24 Mr. Rice who will, after you are through with your
25 two briefs, perhaps ask you some questions in elucida-
26 tion.

27 THE CHAIRMAN: Before proceeding to any
28 formal identification of you, as I understand it, you
29 are from Windsor.

30 MR. WILKINSON: Yes.

MR. ROBERTSON: Yes sir.

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are from Windsor.

MR. WILKINSON: Yes.



1
2 THE CHAIRMAN: And you are an officer of
3 the Ontario Association?

4 MR. WILKINSON: Yes.

5 THE CHAIRMAN: And you are also the gentle-
6 man who had something to do with the prescription
7 scheme, if we might call it that, or the prescription
8 insurance scheme in Ontario?

9 MR. WILKINSON: Yes. I am president of
10 the Prescription Services Incorporated.

11 THE CHAIRMAN: If you gentlemen will
12 present your story as you see fit.

13
14 SUBMISSION OF THE ONTARIO ASSOCIATION OF
15 RETAIL PHARMACISTS

16 Appearances: W.A. Wilkinson, Vice-
17 President of the Association

18 N.S. Robertson, Q.C.

19 MR. WILKINSON: This presentation is made
20 by the Ontario Retail Pharmacists Association and is in
21 supplement of the short brief tendered to this Committee
22 on Monday, 3rd October, 1960 (pp. 414 et seq. of the
23 transcript of the Committee's hearings). This brief
24 has been prepared under the direction of a Special
25 Committee of the Association appointed by Council for
26 the purpose and has been approved by such Special
27 Committee.

28 The Association is a voluntary organiza-
29 tion whose membership is composed of pharmacists
30 registered under the Pharmacy Act, R.S.O. 1960, Chapter
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1 Ontario. In 1960 over 68% of store owners or managers
2 were paid members of the Association (2,043 stores and
3 1,400-odd members).

4
5 The governing body of the Association is
6 comprised of its officers (Past President, President
7 and three Vice-Presidents) and a Council consisting of
8 16 District Representatives from 16 districts, four of
9 whom are from Metropolitan Toronto, and the other twelve
10 from Port Arthur on the West, Windsor and Sarnia on the
11 South-West, Sudbury, Kirkland Lake and Pembroke on the
12 North, Ottawa and Belleville on the East, and Central
13 Ontario.

14 Parenthetically it should be pointed out
15 that the Association is a different body than the
16 College. The latter is governed by a Council composed
17 of fifteen members, each of whom is elected from one of
18 fifteen electoral districts. The members of the College
19 Council are not the same persons as those who constitute
20 the Council of the Association. In the result there are
21 a total of 31 members of the Councils of the College and
22 the Association elected from across the Province, who
23 are interested, in the case of the College, primarily in
24 the professional practice of pharmacy, and in the case
25 of the Association in the vocation of serving in the
26 communities and in making a living by the operation of
27 retail drug stores.

28 It is therefore considered and submitted
29 that the Association is representative of the Retail
30 Drug Trade throughout the whole of Ontario.

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2 A statement of the objects of the Associa-
3 tion appears of record on page 415 of the transcript
4 but may be repeated here, as follows:

5 To advance the scientific and
6 professional aspects of pharmacy;

7 To promote the mutual rights and
8 interests of retail pharmacists
9 in Ontario;

10 To develop method and ideals in
11 merchandising.

12 The prescribing and sale of drugs in
13 Ontario is strictly controlled. Reference is made
14 particularly to the Medical Act, R.S.O. 1960, Chapter
15 234, and the Pharmacy Act above referred to, as well as
16 the Food and Drug Act of Canada. Under the Medical Act
17 (sections 51 and 52) only persons registered under that
18 Act may practise medicine, surgery or as a midwife.
19 The Pharmacy Act provides that no person other than a
20 pharmacist or pharmaceutical chemist may retail, dispense
21 or compound any drugs or sell or offer the same for sale,
22 or dispense or compound prescriptions of legally quali-
23 fied medical practitioners or dentists or veterinary
24 surgeons. The Federal legislation controls the marke-
25 ting of specified drugs.

26 No doubt everyone will agree that these
27 protective provisions in the Medical and Pharmacy Acts
28 as well as the Canadian Act are as they should be, so
29 that the six million citizens of the Province of Ontario
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4 use in the practice of medicine.

5 While attention is drawn to the Pharmacy
6 Act generally, as the Statute governing the sale of
7 drugs at retail, the Committee's particular notice is
8 directed to Section 2 (j) of the Act reading as follows:

9 "2. Nothing in this Act

10 (j) affects or interferes with the
11 compounding, dispensing or supplying
12 of poisons or drugs in any hospital
13 or institution approved or licensed
14 under any general or special Act".

15 -

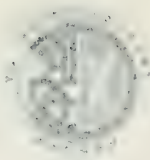
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The members of the Committee will note that the hospitals and public institutions are not subject to the strict regulations imposed by the Statute on druggists and their sale of drugs to the public at large.

I would like to digress for a moment on that from the written brief to state that seems very unusual, it is one of the anomalies of this Act as long as you are out of hospital you have full protection of all the Pharmacy Act, and the moment you enter in hospital you have no protection through the Pharmacy Act.

THE CHAIRMAN: Mr. Wilkinson, is that so? If a person is in the hospital doesn't he have the benefit of a doctor supervising him in the same sense a doctor might prescribe from his own office pharmacy?

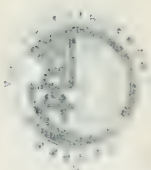
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THE CHAIRMAN: Is he in a doctor's office?

MR. WILKINSON: Under the Pharmacy Act the physician is entitled to dispense medicine for his patients, according to my understanding of the Act.

May I proceed?

THE CHAIRMAN: Is that your answer?



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that the hospitals and public institutions are not
subject to the strict regulations imposed by the
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the physician is entitled to dispense medicine for
his patients, according to my understanding of the
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May I proceed?

THE CHAIRMAN: Is that your answer?



1
2 MR. WILKINSON: Yes sir.

3 The Association observes the Committee's
4 terms of reference which were quoted by the Chairman
5 at Page 5 of the evidence before the Select Committee
6 taken on the 14th of June, 1960, as follows:

7 "Ordered: That a Select Committee of this House
8 be appointed to inquire into, study and review the
9 entire matter of the cost of drugs and pharma-
10 ceutical preparations of all kinds used in the
11 treatment of patients in public, general and
12 mental hospitals and sanatoria in Ontario and
13 all matters relevant thereto, including the present
14 method and practices followed in respect of
15 purchase, distribution, analysis, storage,
16 inventory and accounting thereof in such institu-
17 tions; and in particular as to whether the costs
18 are reasonable, having regard to costs of production
19 and costs charged to the general public;

20 And that such Select Committee shall
21 consist of eleven members, and shall have authority
22 to sit..... the Honourable Speaker
23 to may issue his warrant or warrants."

24 and observes that these terms of reference cover the cost
25 of drugs only as used in public, general and mental
26 hospitals and sanatoria. These are all, no doubt,
27 licensed or established under some general or special
28 act of the Legislature and are therefore under the
29 Pharmacy Act exempt from its restrictions.

30 That the quantity of drugs purchased by

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2 these Public institutions from retail druggists is
3 small is evidenced by the following letter from Mr.
4 G. Morgan, Accounting Consultant of the Ontario
5 Hospital Association:-

6 "ONTARIO HOSPITAL ASSOCIATION

7 Toronto, Ontario.

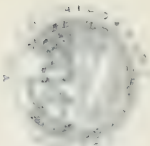
8 May 15th 1961.

9
10 Mr. J.B. Sheppard,
11 Robertson, Lane, Perrett, Frankish & Estey,
12 Barristers and Solicitors,
13 Suite 1111,
14 111 Richmond Street West,
15 Toronto 1, Ontario.

16 Dear Mr. Sheppard:

17 In reply to your letter, I should like
18 to confirm our telephone conversation regarding drug
19 purchases by hospitals.

20 To the best of my knowledge there are
21 no statistics or figures available to show the amount
22 of drugs purchased by hospitals in Ontario from the
23 Drug Wholesalers as compared with the amount of drugs
24 purchased by hospitals from independent druggists
25 during the course of the year. It is fairly accurate
26 to state that in exceptional cases a hospital might
27 purchase a drug from a close independent drug store
28 but generally speaking it is the smaller hospital who
29 would be taking advantage of this source. The published
30 Hospital Financial Statements and the Provincial
Annual Report do not contain comparative figures since
all drug purchases would be under a single heading
"drugs". In my opinion, the bulk of drugs purchased



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2 from independent drug stores would be made by the
3 very small hospitals and would, in fact, be negligible
4 when compared to the total amount purchased, as the
5 large drug houses to-day render a very quick and
6 efficient service.

7 If there are any other specific points
8 upon which I can help you please do not hesitate to
9 let me know.

10 Yours sincerely, "G. Morgan" George
11 Morgan, Accounting Consultant."

12 INQUIRIES MADE BY THE ASSOCIATION
13 AS TO SUPPLY OF DRUGS TO INSTITUTIONS
14 BY RETAIL DRUG STORES.

15 However, to assist the Committee's
16 investigations, the Association has endeavoured to
17 obtain from its member retail druggists such informa-
18 tion as it could as to the volume of sales by retail
19 druggists to hospitals and public institutions, and
20 to obtain information as to the prices charged to
21 institutions by retail druggists.

22 To this end the Association made inquiries
23 of some 1400 retail store operators, members of the
24 Association, and in response received over 400 replies.
25 As could be expected, information as to sales to
26 public institutions came only from sources in communities
27 where public institutions are located and in any
28 event this Committee can readily obtain information
29 as to purchases by institutions from retail druggists
30 by application directly to the institutions concerned.

The druggists reporting sales to institutions all

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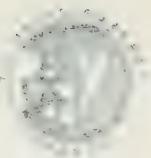
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2 stated that the prices charged were less than regular
3 retail prices to the public.

4 The discount given to institutions varied
5 from 10-25%, and on being averaged the discount given to
6 public institutions worked out at 19.3% less than
7 retail prices.

8 Reference is also made to Professor
9 Fuller's studies of retail drug prices generally as
10 already reported to the Committee in his evidence.
11 See pages 493 et seq of the proceedings of the
12 Select Committee. The Association knows of no other
13 study comparable in its extent to that carried on from
14 year to year by Professor Fuller.

15 The Association wishes to emphasize a
16 point made in Professor Fuller's evidence that retail
17 drug prices in drug stores like other stores, will
18 vary from community to community depending on local
19 conditions, for example rental costs, wage levels,
20 doctors' habits in prescribing, the age of the
21 community's population (whether a majority are elderly
22 people or young people) etc. etc.

23 While perhaps the above completes all
24 the information that is directly useful to the Committee
25 within its framework of reference, it was thought by
26 the Committee of the Association that the following
27 general information as to the place and function of
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1
2 is submitted.

3 THE RETAIL DRUG STORE, ITS PLACE AND FUNCTION

4 From time immemorial and apothecary
5 shop, now the drug store, has served the residents of
6 every community by having drugs readily available.
7 Throughout Ontario a retail drug store (to an aggregate
8 over the whole Province of 2040-odd stores) is located
9 in every settled community where the demand exists -
10 in villages, towns, small cities and metropolitan areas.
11 In most places, particularly the smaller centres, the
12 drug store is the service centre of the community.

13 Originally drug stores were operated by
14 persons trained under the apprenticeship system and
15 in England they were controlled by the Apothecary's
16 Guild. With the rapid development of science generally
17 over recent decades, and particularly since the last
18 war, it became necessary to extend the training of
19 pharmacists so that it now is a full four University
20 year course, plus 18 months of apprenticeship.
21 Without such training the pharmacists would not be
22 qualified to handle and dispense today's drugs with
23 skill and safety. Every drug store dispensing
24 prescriptions must by Statute be in charge of a
25 registered pharmacist, and it serves its community
26 by keeping immediately available an adequate supply
27 of drugs for use as required. Of all retail shops
28 in any community, the retail pharmacist's shop is
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2 day work week and is also open on Saturday and Sunday.
3 The drug store's place and function is to be conveniently
4 located in the community it serves and to keep a supply
5 of drugs, medicines and sick room supplies at all times
6 available.

7 HOW THE DRUG STORE OPERATES

8 While the druggist compounds, dispenses
9 and supplies drugs for illnesses and infirmities of
10 all kinds, he is not a manufacturer of the basic
11 substances used in his profession. Like other retail
12 shops, the drug store operator must buy his supplies
13 of basic drugs, ingredients and supplies from others -
14 wholesalers and manufacturers.

15 However, unlike other retailers, he is
16 not allowed to promote the sale of drugs or prescriptions.
17 He must wait until the attending physician prescribes
18 for his patient, and then the patient under the need
19 of medication initiates the transaction by coming or
20 sending to the drug store to buy what has been
21 prescribed for him.

22 In fixing the price to be charged for
23 the drugs or prescription, the druggist must recover
24 his total cost, and in addition provide a living
25 for himself and family, and also be reasonably compen-
26 sated both for his service to the community to the
27 standard required by law and for the considerable
28 liability he takes on in his daily business of dis-
29 pensing drugs, to which he exposes himself.

30 A druggist's costs fall to be determined

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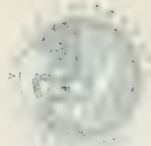
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pensing drugs, to which he exposes himself.

A druggist's costs fall to be determined



1
2 under the general headings of fixed capital, operating
3 capital and operating expenses or overhead:-

4 Fixed Capital - the amount invested in setting up
5 and equipping the dispensary and
6 other departments of the drug
7 store.



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2 Operating Capital - the amount invested in the neces-
3 sary stock of drugs and pharma-
4 ceuticals necessary for service
5 for the needs of the community
6 and other sundry items carried
7 in the drug store.

8 Expenses or Overhead - the amount which has to be laid
9 out from day to day to carry on,
10 including rent, repairs, light,
11 heat, taxes, (both real property
12 and income taxes) licenses,
13 express freight, transportation,
14 delivery expenses, telephones,
15 wages of at least one pharmacist,
16 employees insurance, Workmen's
17 Compensation Assessments, Unem-
18 ployment Insurance contributions,
19 and other outlays incidental to
20 operating a drug store.

21 The cost, amount and availability of
22 fixed capital and operating capital will vary from
23 place to place and with size of drug store. A drug
24 store serving a village or town will require smaller
25 premises and dispensary and smaller stock than one
26 serving a city. Similarly expense items will vary from
27 place to place.

28 In connection with the cost of a prescrip-
29 tion (excluding the pharmacist's living and compensation
30 for his special training and his skill, responsibility

Operating Capital - the amount invested in the necessary stock of drugs and pharmaceuticals for the needs of the community and other sundry items carried in the drug store.

Expenses or Overhead - the amount which has to be paid out from day to day to carry on, including rent, repairs, light, heat, taxes, (both real property and income taxes) licenses, and other outlays incidental to operating a drug store.

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In connection with the cost of a prescription (excluding the pharmacist's living and compensation for his special training and his skill, responsibility



1
2 and community service), the Association points out that
3 the Retail Druggist has no control over many cost items
4 including:

5 (a) The cost of finding or paying interest
6 on his fixed or operating capital -
7 he has no control over fiscal policy
8 or interest rates, and unlike grain
9 growers or railway workers, he receives
10 no subsidy;

11 (b) The druggist does not manufacture,
12 so has no control over the prices of
13 basic materials or supplies;

14 (c) He can do nothing to increase his
15 volume of drug sales and thereby
16 reduce his cost by volume purchasing,
17 the volume of prescriptions depend
18 on the health or ill-health of his
19 community;

20 (d) His rent is determined from time to
21 time by the rental market in his
22 community and for the type of suitable
23 premises he can afford;

24 (e) His taxes at all levels of government
25 are perhaps even beyond his influence,
26 let alone control;

27 (f) The freight or express he must pay is
28 determined by Government Board or
29 Commission on fixed tariff;

30 (g) The wages of pharmacists depend on

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(g) The wages of pharmacists depend on



1
2 supply and demand and the general wage
3 level;

4 (h) The contribution under the Workman's
5 Compensation Act and the Unemployment
6 Insurance Act have been added to the
7 expenses of operating the drug store.
8 Both the pharmacist partners and
9 employees have no occasion to make a
10 claim under the latter and very seldom
11 in the history of the profession under
12 the former.

13 Dispensing pharmacists' average starting
14 salaries, including so-called fringe benefits, increased
15 as follows:

16	1941	-	\$40.00	per week
	1945	-	50.00	" "
17	1949	-	76.00	" "
	1953	-	86.00	" "
18	1955	-	91.00	" "
	1957	-	101.00	" "
19	1959	-	125.00	" "
20	1961	-	126.00	" "

21 and while there are many one-man (probably over 600)
22 drug stores in Ontario, if a druggist is to give the
23 service the public expects of him, he must work 12 hours
24 a day, six days a week and seven hours on Sunday.

25 The conclusion reached by Professor Fuller,
26 as the result of his studies, extending over a number
27 of years, was that the average price of a prescription
28 to the public for the whole of Canada in 1959 was \$2.98.
29 This Association believes as a result of its inquiries
30 that the average price per prescription in Ontario to

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2 the public is about \$3.30 in the year 1961. The price
3 of a prescription is somewhat higher in Ontario because
4 wage levels for dispensing pharmacists are on the average
5 higher in Ontario than in other parts of Canada, and
6 pharmacists' wages are the largest single factor in the
7 cost of dispensing prescriptions.

8 THE SIMPLE ECONOMICS OF THE NEIGHBOURHOOD DRUG STORE

9 The most important single submission this
10 Association wishes to place before the Select Committee
11 is that in order to bring the services of the pharma-
12 cists to the majority of the population of this Province,
13 it is essential that either

14 (a) the price of prescriptions be very
15 substantially increased (more than
16 doubled in many instances), or

17 (b) that the large part of the cost of
18 operating a Drug Store be borne by
19 the sale of non-dispensary items on
20 a considerable scale and in the face
21 of competition from variety stores,
22 super-markets and other retail outlets.

23 No doubt there are many courses which the
24 business of the sale of drugs in the community might
25 have followed in its evolution, but in Ontario and
26 indeed throughout North America, a wide-spread drug
27 service to the general public has been developed on a
28 basis of a community service centre - the Drug Store.
29 There may be many factors behind the growth of the Drug
30 Store to its present status, but no doubt one factor

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1 has been the long distances between centres of population
2 on this continent and the difficulty of establishing
3 qualified outlets for the sale of prescription drugs and
4 pharmacy items in outlying centres of small population.
5

6 In the result, Ontario has about 2,100
7 such drug stores, all of which have in common only the
8 pharmacy department or the dispensary. There are very
9 few Drug Stores in Ontario reporting over 50% of their
10 gross sales from prescriptions and these are confined
11 to the metropolitan areas and usually in association
12 with a concentration of doctors' offices. At the other
13 end of the scale there are many drug stores which do not
14 do more than 10% of their business through the dispen-
15 sary. In between these positions lie the vast bulk of
16 the Drug Stores, each of which has an active dispensing
17 business, but the greater bulk of gross revenue is taken
18 in through the traditional Drug Store departments; for
19 example, cosmetics, tobacco, magazines, camera supplies,
20 household remedies, sick room and household supplies,
21 baby foods, etc.

22 The reason for this development can be
23 very simply illustrated. The average ratio of prescrip-
24 tion revenue to gross store revenue, according to the
25 survey of this Association, as will be described in oral
26 submissions, is slightly over 20%. It is safe to
27 conclude therefore that in the large majority of cases
28 the druggist for some reason finds it necessary to
29 diversify and supply a service to the community well
30 beyond the limits of his dispensary. Let us now

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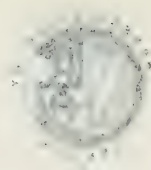
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1
2 examine the reasons for this in more detail.

3 Taking the average results of our survey,
4 we find the average gross sales of drug stores in
5 Ontario is slightly over \$100,000.00 per store per year.
6 Of this about \$20,000.00 is dispensary revenue. The
7 gross profit from dispensary sales is about 50%, leaving
8 about \$10,000.00 to cover the cost of operating the
9 dispensary. Bearing in mind that drug stores remain
10 open for long periods, averaging about 80 hours a week,
11 and the requirement of the law that a graduate licensed
12 pharmacist be in attendance at all times when the store
13 is open to the public, the wage costs of a dispensary
14 are very much higher than in normal retail outlets.
15 For example, a store operating for such long hours
16 requires two pharmacists on its staff and some part of
17 their salaries must, of course, be charged to the dispen-
18 sary. The average wage cost of a pharmacist is about
19 \$135.00 per week whereas the average wage of a sales-
20 clerk (a non-professional) is about \$40.00 per week.
21 Assuming that one half of the pharmacists' salaries
22 are charged to the dispensary (on the basis of time
23 devoted to the dispensary a higher proportion is
24 properly so chargeable) the wage cost at average pharma-
25 cist wages of \$135.00 weekly amounts to about \$7,000.00
26 per annum. Finally, if we assume, and our oral submis-
27 sions will verify this assumption, the general overhead
28 of a Drug Store properly referable to the dispensary,
29 amounts to about 2% of total sales or about 10% of
30 dispensary revenue. Thus a further charge against this



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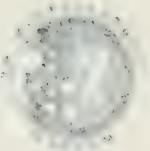
amounts to about 2% of total sales or about 1% of

dispensary revenue. Thus a further charge against this



gross profit of \$2,000.00 is made.

The result is a profit of about \$1,000.00 per year. This profit is earned as a result of an investment of about \$6,000.00 on the average in inventory including up to 4,500 drug items depending upon the nature of the market served, as well as an investment in store equipment, fixtures and furnishings. Expressed in terms of sales the dispensary net profit is less than 5%. It is impossible to determine the segregated return on capital invested.



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The foregoing cancellation (sic) of course, assumes that a pharmacist receives no more than \$135.00 a week regardless of his four years University training and apprenticeship, and whether or not the pharmacist also has many years of practical service experience, and allows nothing for his risk and responsibility in dispensing potentially dangerous drugs.

It must be borne in mind that this is a breakdown of the average store accounts and assumes one half of the pharmacists' salaries ---

THE CHAIRMAN: I don't understand the third word in the second paragraph.

MR. WILKINSON: That should be calculation, I am sorry.

--- and 90% of the general overhead of the store is carried by the non-dispensary services. If more of the general store overhead portion of the pharmacists' salaries were to fall upon the dispensary, then the dispensary would operate at a loss. Thus it can be seen that in the case of the average Drug Store, the dispensary could not at the present prescription price level exist.

The Statement of Revenue and Expense as above.

Using the Dispensary Sales	\$20,000.00
Direct Material Costs	<u>10,000.00</u>
Gross Profit	\$10,000.00



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Gross Profit	\$10,000.00
Direct Material Costs	<u>10,000.00</u>
Using the Dispensary Sales	\$20,000.00



1		\$10,000.00	
2	With Expenses		
3	One-half pharmacists' (2) wages	\$7,000.00	
4	General Overhead regarding the dispensary	\$2,000.00	
5	Leaves a Dispensary net profit	\$1,000.00	
6			
7		\$10,000.00	\$10,000.00
8			

9 In oral submissions we will analyse
10 the figures for the same average store with respect to
11 the sale and resultant net profit of non-dispensary
12 items, and this will show a similar net profit of about
13 \$2,000.00, including part of the Proprietor's salary,
14 and that of the second pharmacist, as above.

15 To the best of this Association's
16 information there was a decrease in the number of
17 stores in this province between October 1957 and
18 October 1960 of 140 stores. This decline occurred in
19 the face of a rising population in this Province.
20 This decline is understandable in the light of the
21 figures set out earlier in this brief. It is equally
22 understandable that there are at present about 200
23 drug stores in Ontario for sale, but the owners have
24 as yet been unable to find buyers.

25 It is therefore, evident that a drug
26 store of average size in the average community, must
27 include non-dispensary departments, in ratio of sales
28 of about five to one over the dispensary, in order to
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2 pharmacist can only be carried to the community outside
3 the two or three densely populated parts of the Province
4 by the supporting revenues of the other departments
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6 ments can be said to subsidize the dispensary (and we
7 believe this is in fact the case) becomes an academic
8 debate because without these other departments the
9 pharmacist would not be able to serve the vast bulk
10 of the Ontario community.

11 Finally, we draw to the Committee's
12 attention several considerations which must be taken
13 into account when examining the services of a Drug
14 Store to the community.

15 (a) The inventory required in the dispensary
16 is varied and expensive. There are, as
17 we have said, up to 4500 separate drug
18 items in the druggists inventory and the
19 cost of this drug inventory is out of
20 proportion to the ratio of dispensary
21 sales to total sales.

22 (b) This inventory includes many items of
23 limited shelf life, and the cost of this
24 natural deterioration must be borne
25 by the druggist.

26 (c) Man-made obsolescence in the form of
27 changing prescribing habits of the medical
28 practitioner and technical progress in
29 chemo-therapy likewise increases the
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2 dispensary.

3 (d) The dispensary is the emergency ward of
4 the retail world, and the public requires
5 that it be maintained on that basis.

6 (e) Because of the serious consequences of
7 an error in the supply of drugs to the
8 patient, the responsible pharmacist owes
9 a duty to the public to provide drugs in
10 the most reliable form possible and
11 manufactured by organizations who maintain
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16 (f) The increasing complexity of drug
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21 In the foregoing brief outline, we have
22 sought to apprise this Committee of the essential
23 characteristics of the Drug Store as an institution
24 in the life of the Province, as well as to respond to
25 the more limited issues raised by the terms of
26 reference of this Select Committee. This presentation
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29 THE ONTARIO RETAIL PHARMACISTS ASSOCIATION.

30 May 26th, 1961.

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2 THE CHAIRMAN: One question on the
3 broad issues which you have raised, having in mind the
4 general premise and the theory of your brief, which
5 indicates that on the average drug stores in Ontario
6 derive twenty per cent of their sales volume from the
7 drug subjects we are interested in, and that the
8 maintenance and availability of that service to the
9 community requires the support, or leans on the
10 support of the other eighty per cent of so-called
11 sister items. Is that a correct statement of the
12 principle in the brief?

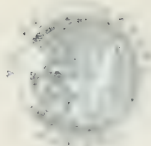
13 MR. WILKINSON: Yes sir.

14 THE CHAIRMAN: Then, Mr. Wilkinson, if
15 there were any change in the cost of your raw materials
16 which reduced the prices and reduced your profit, is
17 it the theory of your submission that there would be
18 a greater burden placed, and a greater dependency on
19 the other eighty per cent of non-drug sales?

20 MR. WILKINSON: If I understand your
21 question sir, if the dollar volume of this 20% were to
22 be decreased by any means, would it make it more
23 difficult for us to do business?

24 THE CHAIRMAN: The means I have in mind
25 would be a reduced price of drugs, a reduced cost of
26 drugs to the retail pharmacists.

27 MR. WILKINSON: A reduced cost of drugs
28 to the retail pharmacists would mean a reduced price
29 of drugs to the patient, and it would no doubt be
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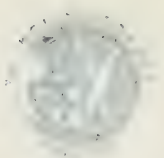
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THE CHAIRMAN: The total number of prescriptions or drug sales might increase, the proportion of drug sales in your store might remain the same due to offsetting influences.

MR. WILKINSON: I wouldn't be able to say how it would operate over the broad picture, but as a person who has been practising pharmacy for 30 years, we have always made a small, nice living from both sides of our business, and all through these years there have been varying prices of medication and new items appearing and old items disappearing, and it always seems to balance out.

THE CHAIRMAN: I am sorry I interrupted you.

MR. WILKINSON: I have been asked to present this brief on my own operations, and with your permission I will read it without omitting anything, although I have already been introduced.

My name is William Arthur Wilkinson, born 1909, and I am a graduate from Toronto University in Pharmacy 1931. I own and operate a drug store at 501 University Avenue, W., Windsor, Ontario. Except for the period 1940 to 1946 during which interval I served in the Royal Canadian Navy, I have spent my entire lifetime in the merchandising and dispensing operations of a retail pharmacy. Beginning as a delivery boy at twelve years of age while still attending school, through an apprenticeship to graduation and ultimate purchase of the family business established by



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1
2 my father, A J. Wilkinson, on the same corner in 1894,
3 just 67 years ago.

4 Ours is a neighborhood business, gradually
5 becoming downtown and in the process going through
6 a period of centre city decay so common to all
7 municipalities due to growth and expansion of the
8 suburbs. Thus we deal with many families as residents
9 in the area as well as a fairly large transient clientele.

10 We do not number among our customers any
11 hospital, city, county, provincial institution or
12 department unless it could be considered that prescrip-
13 tions filled in the normal course of business for
14 D.V.A., armed forces, workmen's compensation and
15 city welfare fall in those categories. The small
16 number of all but city welfare, never exceeding 7 or
17 8 a month, are billed at our regular "patient price".
18 City welfare by agreement with the welfare administration,
19 are billed at patient price less 15%. The latter
20 fluctuates between 40 and 60 prescriptions a month.
21 For the above reason it is possible that I may not be
22 very helpful to you in determining how to reduce costs
23 of drugs in institutions which I understand to be the
24 committee terms of reference.

25 I can, however, give to the committee, if
26 it wishes, a fairly comprehensive and, I believe,
27 rather typical explanation of problems, and trials and
28 tribulations which beset a retail pharmacist in the
29 day to day conduct of a dispensing pharmacy.

30 Wilkinson's Drug Store occupies the ground



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day to day conduct of a dispensing pharmacy.

Wilkinson's Drug Store occupies the ground



1
2 floor of 501-521 University Avenue W., Windsor, Ontario.
3 The building was built in 1914 from a remodelled house
4 and added to in 1921. Since purchasing the business
5 in 1946 it has been expanded to take in two small
6 adjoining stores connected by archways. This enables us
7 to operate a self-contained Gift section and a Baby
8 section in addition to the main serving area of the
9 Drug Store in which is located the dispensary or
10 Pharmacy.

11 In 1946 at the time of purchase the stock
12 was valued at \$10,000.00, the fixtures were obsolete,
13 many 40 years or older, and the front in need of a
14 complete remodelling. Since 1946 we have expanded,
15 purchased new fixtures, and the inventory has been
16 increased to \$26,000.00 - nearly all this with borrowed
17 money with the consequence that there is still a very
18 heavy encumbrance against the business. With our
19 floor space of some 2,000 sq. feet we are able to
20 departmentalize into 6 sections for accounting purposes
21 (1) Dispensary, (2) Cosmetics (3) Health & Beauty Aids
22 (4) Baby Goods, (5) Gift Shop and (6) Miscellaneous.
23 By using the facilities of a modern cash register we
24 are able to accurately determine the sales volume in
25 each department. Using our own sales figures 1956
26 to 1960 inclusive and averaging them to workable
27 approximates, I feel free to make public, if you so
28 desire, the following:

29 Average book worth (Stock fixtures etc.)...\$35,000.00

30 Average Sales..... 90,000.00



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27 desire, the following:

Average Sales.....	90,000.00
Average book worth (Stock fixtures etc.)...	\$35,000.00



1
2 Average inventory.....\$26,000.00
3
4 (1) Dispensary\$17,600.00
5 (2) Cosmetics 4,000.00
6 (3) Health Beauty..... 5,800.00
7 (4) Baby 5,500.00
8 (5) Gift 7,800.00
9 (6) Miscellaneous 49,300.00
10 \$90,000.00

11 It is significant to note here that of
12 the \$90,000.00 volume \$17,600.00 or 20% is from
13 Prescriptions (new and repeat).

14 The average annual payroll for assistant
15 pharmacist, clerks and delivery for the same years was
16 \$13,000.00 of which \$1,500.00 was for delivery and
17 \$11,500.00 for all clerks, of which the assistant
18 pharmacist received \$5,300.00, leaving \$6,200.00 for
19 clerks. This does not and I repeat does not take into
20 account any wages for me, the owner and manager, and
21 I work a 50 hour shift in the store each week. Under
22 our accounting system it is customary for the owner-
23 manager who works a full shift opposite his assistant,
24 dispenses, manages, buys, clerks, banks and book-keeps
25 as his duties as the chief executive of the store, to
26 take as his wages and earnings on his investments, the
27 net profit after all other expenses. In this case our
28 total net earnings averaged over the same years as
29 above was \$6,800.00 a year or to put it another way,
30 if my time and work are only equal to my assistant -



1
2 that is \$5,300.00 a year, my earnings on my total
3 investment of some \$35,000.00 is \$1,500.00. How have
4 we come to such a sorry plight in the small neighborhood
5 dispensing pharmacy? Let's take a look at the wage
6 hour picture and then a look at the division of sales
7 between over the counter merchandise and prescribed
8 pharmaceuticals.

9 Firstly:

10 The Pharmacy Act requires a pharmacist on
11 duty at all times the store is open. The
12 store is open 12 hours a day for 6 days
13 and 6 hours on Sundays, or 78 hours a
14 week. Therefore, we must employ an
15 assistant pharmacist and in any event
16 \$90,000.00 volume is too much for one
17 pharmacist to handle but it is too little
18 to adequately pay two pharmacists. The
19 pharmacist and assistant drawing \$10,600.00
20 a year account for only \$17,600.00 of the
21 volume or 20% while the shop clerks
22 drawing a total of \$6,200.00 account for
23 \$72,400.00 or 80% of sales. Now it can
24 be argued that this is not exactly true
25 because the pharmacist does not spend all
26 of his time dispensing and does contribute
27 some sales to the above \$72,400.00. I
28 admit that this is so but would remind
29 the committee that when the pharmacist
30 dispenses that volume of prescriptions,



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1
2 takes care of the ordering and arrangement
3 of pharmaceuticals, sees the necessary
4 travellers, does the banking and book-
5 keeping as well as general supervision
6 of the whole operation he has little
7 time left to make enough sales over the
8 counter to substantially alter these figures.
9 During fiscal 1961, steps have been
10 taken to improve the wage picture by
11 reducing our employees by one full time
12 clerk and one part time girl.
13 As stated previously, our inventory is
14 approximately \$26,000.00 and is roughly
15 divided as follows:
16 Dispensing pharmaceuticals.....\$ 8,000.00
17 Over the counter merchandise... 18,000.00
18 In preparation of this brief an effort
19 was made to determine the number of prescription items
20 required to operate our dispensary and a count of these
21 revealed that:
22 We stock 1800 different pharmaceuticals
23 or dosage forms of Pharmaceuticals. Of
24 these less than 20 are purchased from
25 the so-called Generic-term processors, the
26 balance being trade-name prescription
27 specialties. That is less than 20.
28 The above does not count any of the more
29 than 500 different chemicals and herbs
30 which we still carry in stock against the



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than 500 different chemicals and herbs
which we still carry in stock against the



1 chance that they will be required for
2 compounding some special mixture which
3 may be prescribed.
4

5 Unlike many of the witnesses who have
6 appeared we have no personal financial stake in the
7 Trade name vs. Generic controversy. We carry in stock
8 whatever we must in order to dispense a proffered
9 prescription. Under the law we may not substitute one
10 product for another and would not even if we could.

11 It can be argued that when a pharmaceutical
12 product reaches a pharmacist's shelf it comes to rest
13 and is no longer an item of merchandise but an
14 ingredient of a particular prescription for a specified
15 person ordered by a practitioner who alone has the right
16 to determine what shall be dispensed. If this is so
17 it follows that the dispenser becomes legally
18 responsible for its correct compounding and liable for
19 any damages arising from negligence in dispensing or
20 malpractice and this brings us to the awful responsi-
21 bility assumed by the pharmacist each and every time
22 he dispenses. This responsibility is great enough when
23 dispensing products of proven quality made or processed
24 by companies large or small in whom we have confidence
25 but becomes unbearable when dispensing products of
26 doubtful origin. Although we are heavily insured against
27 a suit arising out of negligence or malpractice we buy
28 our chemicals and pharmaceutical generics such as we
29 need only from houses in which we have grown to have
30 confidence.



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2 We do look upon these preparations for
3 war between the proponents of Trade names vs generics
4 with a good deal of concern because, as the middle man
5 between manufacturer and supplier, each one duplicating
6 the other's formula under a common name, we believe
7 this will inevitably lead to duplication upon duplica-
8 tion with its consequent adverse effect upon our
9 inventory and not as some have said, to a simplification
10 or reduction in stocks required.

11 In the art of prescription writing there
12 is no useful generic language. I should like to
13 underscore that - there is no useful generic language.
14 There are about 30 chemicals which by themselves, in
15 various dosage forms, are used in the treatment of
16 disease. These are known by a common or generic name
17 such as Thyroid, Phenobarbital, ASA, Penicillin,
18 Tetracycline, Chloraphenacal and the like, and may be
19 obtained from a variety of sources at a variety of
20 prices.

21 Beyond these 30 or so, the generic,
22 common or chemical names are so long, cumbersome and
23 multi-syllabled that the physician cannot remember them
24 and the pharmacist would have difficulty in identifying
25 many of them. Many of the 30 or so useful generics
26 included above as well as some sedatives, diuretics and
27 hypertensives lend themselves very well to institutional
28 medicine. They are the tranquilizers, sedatives,
29 sleeping pills, blood pressure reducers and diuretics,
30 doled out dose by dose, in mental institutions, jails,



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2 hospitals and sanatoria, and because great savings seem
3 to be affected by their purchase abroad in great
4 quantities it is believed that similar savings can be
5 effected for the general public in the normal course
6 of their medicine requirements. In type and dosage form
7 of medication, there is little or no similarity in general
8 practice and institutional practice

9 There is not now and I doubt ever will
10 be a generic name for a compound containing two or
11 more generic substances. In these cases the common
12 name becomes a trade name and is protected by a copy-
13 right. This class of mixtures and compounds comprises
14 over 88% of all general practice prescribing. Speaking
15 as a dispensing pharmacist who has to bear the brunt
16 of public criticism, to the manufacturer of both patent
17 and generic names and to the news media and others
18 who have aided and abetted this public quarrel with
19 misinformed and ill-conceived publicity I would say,
20 Mr. Chairman, without being disrespectful "A plague
21 on all their houses".

22 I would like to return if I may to some
23 facts and figures regarding our dispensing operation.
24 We have averaged, as stated above, \$17,600.00 in
25 prescriptions a year. To supply the specialties for
26 these prescriptions, we carry in stock some of the
27 specialties of about 86 pharmaceutical houses. We
28 buy or can buy all of them from the Drug Trading Co.
29 of Toronto or the National Drug Co. with the following
30 discounts from the catalogue price.



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58 @ 40% discount
1 @ 37 1/2% discount
2 @ 35% discount
15 @ 33 1/3% discount
1 @ 32% discount
1 @ 31% discount
1 @ 28% discount
7 @ 25% discount - off of list



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28 @ 40% discount
1 @ 35% discount
2 @ 35% discount
15 @ 33 1/3% discount
1 @ 32% discount
1 @ 32% discount
1 @ 32% discount
7 @ 25% discount
off of list



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2 In actual practice we buy direct from
3 only 12 of the larger companies included in the above.

4 To price our prescriptions we use a
5 schedule based on the 60% formula to which is added a
6 75¢ dispensing fee. This fee is gradually reduced to
7 50¢ on all prescriptions over \$9.00 and becomes 50¢ at
8 the \$11.00 mark. Because of the discounts shown above
9 and the fact that it is common practice nowadays to
10 prescribe in small original shelf packages our gross
11 profit on prescriptions in 38.6%. If, however, you
12 calculate a gross profit on the basis of the specialty
13 and the professional fee our gross profit becomes 50.1%.
14 We do not use the latter method. Returning again to
15 our approximates, our \$17,600.00 volume is derived from
16 5,200 prescriptions or an average of 3.40 a prescription
17 and includes both new and repeat prescriptions. These
18 are average figures for the last 5 years for simplicity.
19 These will vary from store to store and from city to city
20 but will not be significantly different so as to alter
21 the general prescription picture, which is simply this.
22 \$17,600.00 gross in prescriptions at 50% gross profit
23 equals:

24 \$8,800.00 gross profit against
25 which you will recall we already
26 have a bill for wages of \$10,500.00
for the two pharmacists.

27 This is the dilemma of the dispensing
28 pharmacist - is the volume too little per store? Is
29 the price and fee insufficient? Are there too many
30 stores for the population? How great an effect on our



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This is the dilemma of the dispensing pharmacist - is the volume too little per store? Is the price and fee insufficient? Are there too many stores for the population? How great an effect on our



1 volume are (1) The dispensing doctor? (2) Hospital
2 outpatient dispensing? (3) Group practice clinics?
3 (4) Mail order houses? (5) The cutraters and the discoun-
4 ters?

5
6 Perhaps all of these have some effect but
7 we in retail pharmacy can see no way of limiting or
8 eliminating any of them, without placing the whole
9 industry within a controlled economy and this does not
10 seem to be a very desirable or practical solution.

11 It would seem to us that the Ontario
12 Government, as a purchaser and dispenser of pharmaceuti-
13 cals has a giant sized retail pharmacist problem, but
14 the same problem nevertheless, and perhaps the solutions,
15 lie in the same direction. Aside from nationalizing
16 the whole industry and profession the following alterna-
17 tives seem to be open to reduce the cost of drugs.

18 1. Buy cheaper drugs and dispense them
19 without concern as to their purity or
20 standardization.

21 2. You can buy cheap drugs and set up
22 testing laboratories to test and standar-
23 dize the products, the cost of which would
24 likely nullify any savings.

25 3. We could request legislation to enforce
26 purity and standardization at the product
27 level.

28 4. Or we can buy only pure and standar-
29 dized products from companies of known
30 reputation whose physical facilities for



Volume are (1) The dispensing doctors (2) Hospital

(4) Mail order houses (5) The outpatients and the discom-

pany

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4. Or we can buy only pure and standard-

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1
2 testing are known and inspected by proper
3 authorities and who because of their repu-
4 tation could not escape the moral and
5 legal responsibility in the case of a
6 fatal experience with one of their products.

7 While the morale of the profession of
8 Pharmacy is, at this time, at an all time low, and while
9 repeated attacks on the industry, the brunt of which has
10 been borne by the dispensing pharmacist, have caused
11 many of us to wonder what lies ahead, I do not share
12 the opinion of many in Pharmacy that all is lost. It is,
13 however, a matter of some concern to all of us that so
14 many stores are now for sale, that there is an ever-
15 growing reluctance to buy or open in a small town, that
16 some 800 stores in Ontario are without an assistant
17 pharmacist, unable to find one and in many cases to pay
18 the wages if one is found. It could be that the centre
19 of the health services in many many communities will
20 disappear with the present incumbent.

21 Respectfully submitted, sir.

22 THE CHAIRMAN: I wonder if this would be
23 a good time to have a five-minute break.

24
25 --- Short Recess

26
27 MR. ROBERTSON: Mr. Chairman.

28 THE CHAIRMAN: Yes, Mr. Robertson.

29 MR. ROBERTSON: You may want to ask Mr.
30 Wilkinson some questions, but with your permission, we



testing are known and inspected by proper
authorities and who because of their reputa-
tion could not escape the same and
legal responsibility in the case of a
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the opinion of many in Pharmacy that all is lost. It is,
however, a matter of some concern to all of us that so
many stores are now for sale, that there is an ever-
growing reluctance to buy or open in a small town, that
some 800 stores in Ontario are without an assistant
pharmacist, unable to find one and in many cases to pay
the wages if one is found. It could be that the centre
of the health services in many communities will
disappear with the present incumbent.
Respectfully submitted, sir.

THE CHAIRMAN: I wonder if this would be

a good time to have a five-minute break.

--- Short Recess

MR. ROBERTSON: You may want to ask Mr.

Wilkinson some questions, but with your permission, we



1 have two gentlemen from out of town, Mr. Donaldson and
2 one other. Mr. Donaldson closed his store to come here.
3 He is one of the one-man drugstores, so his stores and
4 his customers and his community are without service this
5 afternoon in Renfrew. I would like, with your permis-
6 sion, to have him present what the situation is as a
7 one-man drugstore before you proceed if you want to
8 question Mr. Wilkinson.
9

10 THE CHAIRMAN: I appreciate the situation.
11 I think I speak for all the Committee when I say we are
12 grateful to Mr. Donaldson for having come down, and the
13 others from out of town. We would like to convenience
14 them as far as possible, and will.

15 MR. ROBERTSON: I would like to call him,
16 Mr. Donaldson. May I present Mr. Keith Donaldson from
17 Renfrew.

18 MR. DONALDSON: I must apologize for
19 having to read most of my notes because of the fact it
20 was late Monday night when I completed my notes and I
21 had to drive to Toronto last night after closing.
22 Incidentally, as you know, I must drive back tonight if
23 I expect to be open tomorrow.

24 Rising overheads, heavier inventories,
25 increasing competition by non-drug outlets and decrea-
26 sing profits in the many departments of the drug store
27 are placing a serious strain on the pharmacists in my
28 area. It is overhead due to a great extent to what we
29 have been expected to pay graduate pharmacists today
30 and experienced store personnel. It has increased to

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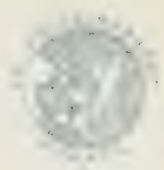
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1 the point that we have been unable to meet them in the
2 smaller towns, and it has forced us to reduce our
3 essential services to the public by curtailing substan-
4 tially our hours.

5
6 Two years ago there were nine pharmacists
7 in Renfrew. Today there are five, and one part-time
8 pharmacist over 75 years of age. The grim picture is
9 that this number may again be reduced within a short
10 time due to the fact we are unable to replace our
11 graduates, the long week, the costly investment in
12 education and stores and the heavy legal responsibilities
13 and the swollen credit ledgers. I might say a word on
14 the smaller town, a town like Renfrew. We are expected
15 to charge substantial amounts every year. At the
16 present time I have fifty-three hundred and some-odd
17 dollars of credit on my books. There are no finance
18 houses to come around and relieve us of that responsibi-
19 lity and that heavy investment. It is expected of us,
20 and the other stores bear the same, or have the same
21 picture with the credit situation. A person comes in
22 to have a prescription filled. They haven't the money.
23 We know their credit is bad, but we cannot let them do
24 without medicine so we put it on our books. A good
25 many times, all too often, too many times we never get
26 that money back so it is easily understood that \$5,300
27 could be increased each year.

28 The long hours, the costly investment in
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1
2 financial returns are definitely not commensurate with
3 his qualifications, investments and responsibilities.
4 They are proving costly to the future protection of the
5 health and welfare of the public by trained and
6 qualified persons.

7 We haven't had one boy or girl from Renfrew
8 enter pharmacy in the last eight years in spite of the
9 fact that we have pharmacists go over to the high
10 school, the 13th grade, and give them information on
11 pharmacy. Not one boy has come forward, or one girl,
12 to enter pharmacy. It is an alarming situation.
13 Normally the boys and girls that leave a town such as
14 Renfrew to enter some profession return.

15 THE CHAIRMAN: Is that the situation,
16 Mr. Donaldson, from your knowledge or experience that
17 is prevalent in other towns in Ontario such as Renfrew?

18 MR. DONALDSON: It is right throughout
19 the Province today. I think there is only one pharma-
20 cist - there have been only three boys come up from
21 Renfrew in the last 12 years. There was one from Arn-
22 prior in the last 9 years.

23 MR. WREN: What is your population?

24 MR. DONALDSON: 8,600 in Renfrew.

25 THE CHAIRMAN: It is an enlistment or
26 replacement or recruiting problem?

27 MR. DONALDSON: It is one we have done
28 every effort to correct. We have done a great deal to
29 try and improve the picture. These boys who go to
30 school and spend four years at the University of Toronto,



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2 18 months apprenticeship and an inventory of \$10,000
3 are certainly not going to choose pharmacy as a career
4 at the wages they can expect when they get through and
5 for the legal responsibilities they must assume in their
6 vocation.

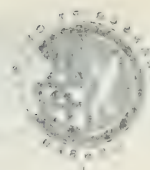
7 THE CHAIRMAN: I suppose you are saying
8 this profession is not attractive to potential applicants?

9 MR. DONALDSON: It isn't because on the
10 one hand, I think at least, is our position in the
11 community. Doctors, lawyers, dentists all live on a
12 better scale than the pharmacist does. These boys and
13 girls today are looking for the financial returns. They
14 are not looking at the humanitarian methods. They want
15 returns.

16 THE CHAIRMAN: I regard that as a rather
17 important situation for this Committee.

18 MR. DONALDSON: It is an important situation
19 and one that is causing us grave concern. How we can
20 correct it, I don't know.

21 Over and above that \$6,000 in the average
22 dispensary can't be promoted for sale; in other words
23 in our dispensary and we cannot sell them without the
24 prescription - approximately 70% of the prescriptions
25 filled cannot be legally refilled. For instance, for
26 a prescription of phenobarb - a doctor prescribes two
27 dozen phenobarb and the patient has the prescription
28 filled. He wants it refilled and we have to call the
29 doctor or make the patient go over to the doctor to get
30 another prescription. That is in 70% of the



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1 prescriptions we fill - this is from a survey made in
2 Renfrew - cannot be refilled without the extra work.

3 MR. WHITE: 70%?

4 MR. DONALDSON: Pardon?

5 MR. WHITE: 70%.

6 MR. DONALDSON: Well, I got the 70% from
7 taking three months from my own prescription work,
8 which I assume would be pretty much the same with all
9 the other stores, and I broke it down with that.
10

11 -

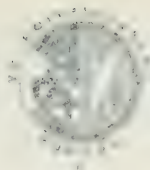
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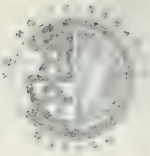
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Selecting and maintaining the multiplicity of drugs in the average dispensary can only be done by a pharmacist. Seventy-five per cent of the drugs in use today were not available ten years ago. Roughly 500 new drugs are produced each year.

I would like to just give you these figures to illustrate the problems that we are faced with with new drugs. This was a survey made in Renfrew last week by the other stores and myself. We took two of the better known drug classifications, the antibiotics and ataratics which is the field of tranquilizer drugs and their compounds, and on our shelves were 161 different forms and doses of antibiotics alone and 139 of the ataratic drugs. That doesn't mean size. That means different forms and strengths.

Besides that, one firm had eight different strengths of penicillin. Besides these, I might say, we are expected to maintain those drugs. We have to have them when the doctor prescribes them. Besides these are the sedatives, diurectics, narcotics and many others; none of which can be sold and none of which can be legally repeated without the order of the doctor.

When one considers the vast number of partly filled bottles left in our hands, one can appreciate that dispensing must be subsidized by the rest of the store. A little incident happened to me three months ago that I would like to use as a sample of this partly filled bottles. I had a prescription



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1
2 for one dozen trancopolin pills, a drug that is
3 prescribed for a person that is very emotionally upset.
4 I dispense the dozen out of the bottle and I haven't
5 had a call since and I doubt if I will. It's only for
6 very highly specified cases that a drug of that type
7 is used but yet we have that drug for the public
8 safety. Now I am left with that bottle of medicine
9 at a considerable cost to myself and that is only one
10 of a great number of others. This is a problem that
11 we have never been able to solve.

12 Coupled with the filling of the prescrip-
13 tions is the necessary task of keeping records which
14 include a drug purchase book, a schedule D book, a
15 narcotic record book and the daily prescription entry
16 book. Here again only a pharmacist can make these
17 entries.

18 The new 3% tax which has been added, and
19 to which I would like you to know that we do not object,
20 but this 3% tax is going to make another record book
21 and it is going to make a considerable increase in our
22 bookkeeping in the drug store.

23 Due to the fact that we in Renfrew serve
24 a fairly big area in many parts of which there are
25 no doctors, and a drug store would be impractical, we
26 have assumed the responsibility of protecting our
27 people by having a pharmacist available twenty-four
28 hours a day, 365 days a year. A very heavy but
29 essential committment for the protection of our people.
30 We have no hospital dispensary in Renfrew; no public



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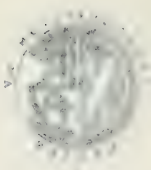
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3 come from the big territory in to see a doctor and at
4 the doctor's request, we have adopted this routine so
5 that the doctor and the patient won't be running all
6 over the country trying to get a prescription filled.

7 THE CHAIRMAN: That is a voluntary effort
8 by the druggists?

9 MR. DONALDSON: Yes. The only way a
10 one-man drug store can have a holiday is to close the
11 store entirely and if the present shortage of pharmacists
12 continues, this practise may be forced on many more,
13 leaving areas without the vital service offered by
14 the pharmacist.

15 In spite of mountains of false propoganda
16 hurled on the public, no change in our public attitude
17 has been evidenced towards us. I can assure you that
18 the people's faith in the integrity and fairness of
19 the pharmacist, the people's respect for his unselfish
20 and all to often unrewarded dedication to the health
21 of the community is not diminishing in Refrew and the
22 surrounding towns.

23 We fully realize that the public thinks
24 only of the cost factor and we cannot blame them too
25 much for doing so but we who are involved in the health
26 and welfare of the public, we who must accept the
27 legal responsibility of malpractise in every prescrip-
28 tion, we feel we have an obligation to see that the
29 public receives only the very best and most reliable
30 drugs at all times. We cannot and we must not take



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2 chances with the lives of the public we serve. Price
3 must never precede quality and reliability.

4 The pharmacists in the Ottawa Valley whom
5 I represent adamantly refuse to jeopardize this by
6 substituting drugs of proven purity, reliability and
7 quality for those of questionable quality that are,
8 through price appeal, commonly being foisted on a
9 gullible public.

10 Pharmacists of integrity have always
11 adopted this attitude: If I wouldn't dispense it for
12 my family, I wouldn't dispense it for the people who
13 depend on me. That completes my submission.

14 THE CHAIRMAN: Mr. Donaldson having in
15 mind the position of the type of druggists you
16 represent in a town such as Renfrew having in mind the
17 working and habits of the people in such a town would
18 you think that the requirements of the Pharmacy Act
19 are too onerous in requiring a licensed pharmacist
20 on duty at all times?

21 MR. DONALDSON: Definitely not.

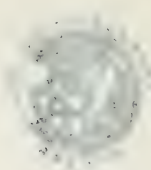
22 THE CHAIRMAN: No?

23 MR. DONALDSON: No. In fact I think if
24 I might voice my opinion on that, I don't think the
25 Pharmacy Act is protective enough today. May I take
26 a minute --?

27 THE CHAIRMAN: Yes, please do.

28 MR. DONALDSON: Today, the feed stores
29 have been permitted to sell antibiotics.

30 THE CHAIRMAN: Feed stores?



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THE CHAIRMAN: No?

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THE CHAIRMAN: Yes, please do.

MR. DONALDSON: Today, the fact is that have been permitted to sell antiseptics.

THE CHAIRMAN: Read across



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2 MR. DONALDSON: Feed stores.

3 THE CHAIRMAN: You mean for animals?

4 MR. DONALDSON: For animals, chickens and
5 things of that nature. They are in hands who know
6 nothing entirely about it and I am very much concerned
7 about the fact ~~that~~ some of these antibiotics may be
8 taken by the public. There is streptomycin, aureomycin,
9 things of that type. They are familiar with those
10 terms today. They think well if my horse didn't die
11 with it, why can't I take it? Take this and that, and
12 it can be a serious, fatal matter.

13 THE CHAIRMAN: In other words, stricter
14 control?

15 MR. DONALDSON: I would certainly say so.

16 THE CHAIRMAN: Is there a large proportion
17 of your drug sales to veterinary purposes?

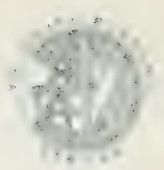
18 MR. DONALDSON: Not in my store, no. One
19 of the other stores does quite a large volume of it.
20 We do maintain stocks for the farmers in case of the
21 other store being closed. For the amount I sell, I
22 should be out of it but we still maintain it for their
23 protection, and their stock protection.

24 MR. RICE: Mr. Donaldson do you consider
25 five pharmacists in Renfrew having stores how many?

26 MR. DONALDSON: Four.

27 MR. RICE: Four drug stores. Population
28 of 8,600?

29 MR. DONALDSON: That is right. And quite
30 a large population in the surrounding district.



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2 MR. RICE: They serve a large population
3 in the surrounding area?

4 MR. DONALDSON: Yes.

5 MR. RICE: You sort of struck an alarm
6 note there with regard to young fellows not wanting
7 to go into pharmacy; go into this type of business and
8 also about the expansion of drug stores into other,
9 allied lines. Would this be the trend of stores in
10 merchandising generally? For instance, the corner
11 grocery store is now almost a thing of the past, with
12 the large supermarkets and so on and they are even going
13 into the hardware business. Is the drug store also
14 having this difficulty with expansion programme going
15 on? Stores getting larger and larger?

16 MR. DONALDSON: There is something to that,
17 but the larger store is not giving the same service that
18 the independent druggist will.

2 19 MR. RICE: Then would the solution be
20 to confine drug stores strictly to a sale of drugs and
21 in that way reduce the number of stores?

22 MR. DONALDSON: If it were practical,
23 yes, but as we are set up today it wouldn't be
24 practical. The returns of your dispensary, as I said
25 here we do not derive enough revenue to meet the prices
26 or the wages expected today.

27 MR. RICE: If there was only one store in
28 Renfrew confined in this area would that not get all
29 the business?

30 MR. DONALDSON: They could, but if they

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MR. RICE: If there was only one store in
or the wages expected today.

here we do not derive enough revenue to meet the prices
practical. The returns of your dispensary, as I said
yes, but as we are set up today it wouldn't be

MR. DONALDSON: If it were practical,
in that way reduce the number of stores?

to confine drug stores strictly to a sale of drugs and
MR. RICE: Then would the solution be
the independent druggist will.

but the larger store is not giving the same service that
MR. DONALDSON: There is something to that
on? Stores getting larger and larger?

having this difficulty with expansion programme going
into the hardware business. Is the drug store also
the large supermarkets and so on and they are even going

grocery store is now almost a thing of the past, with
merchandising generally? For instance, the corner
allied lines. Would this be the trend of stores in

also about the expansion of drug stores into other,
to go into pharmacy; go into this type of business and
note there with regard to young fellows not wanting

MR. RICE: You sort of struck an alarm
MR. DONALDSON: Yes.

in the surrounding area?

MR. RICE: They serve a large population



1
2 were faced with the hours that the four of us use today
3 -- worked out amongst ourselves, they would still have
4 to have four, at least four pharmacists on duty. I
5 don't see how they could cut it down any less.

6 MR. RICE: Did you say ten pharmacists?

7 MR. DONALDSON: Nine up until two years
8 ago.

9 MR. RICE: This 8,600 population has
10 that been going up or down?

11 MR. DONALDSON: It has remained -- no, it
12 has been going up. It was, as I remember 20 years ago
13 it was around fifty some odd hundred, fifty-two or
14 three. Today's its eighty-six.

15 MR. RICE: Do you find in your business
16 that the dispensing aspect, or the drug part of your
17 business is also increasing? Are you selling more
18 drugs now than you were last year?

19 MR. DONALDSON: Yes, there is a definite
20 increase in prescriptions. We have increased our
21 prescription business each year.

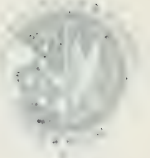
22 MR. RICE: Is this a steady growth?

23 MR. DONALDSON: Very steady growth, yes.

24 MR. RICE: Could you give us any
25 approximate per cent as to how much it increases each
26 year?

27 MR. DONALDSON: Oh roughly about three or
28 four per cent I would say a year. That is just a
29 hazard at it; my own figures.

30 MR. RICE: This amount that you carry on



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1
2 charge accounts do you have a certain write-off each
3 year for bad debts?

4 MR. DONALDSON: Yes, we do. We can use
5 it. I haven't used it.

6 MR. RICE: These people that you carry
7 for a while, you do write them off eventually as a bad
8 debt do you?

9 MR. DONALDSON: We can, yes.

10 MR. RICE: Can you give us any approximate
11 idea of how much you write off in bad debts?

12 MR. DONALDSON: Just offhand I can't
13 recall. I am sorry. I won't commit myself on that
14 figure.

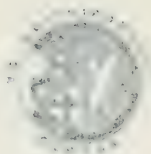
15 MR. RICE: Could you tell us approximately
16 how many drugs you carry within the different kinds
17 of drugs? You told us about 161 -- 139 would be the
18 total different kinds of drugs you carry in your store?

19 MR. DONALDSON: No, that is just two
20 classifications.

21 MR. RICE: What would be the total number
22 of drugs you carry?

23 MR. DONALDSON: It was estimated on a
24 survey made lately that about 4,500 different drugs.
25 I read an article by Dr. Mordell from Princeton
26 University who is a recognized authority in the
27 pharmacology field, pharmaceutical field and his figures
28 quote 150,000 drugs in use at the present time.

29 MR. RICE: I was wondering in a store of
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your nature how many --



1
2 MR. DONALDSON: How many different drugs?

3 MR. RICE: Yes, in stores of your type
4 in a small community.

5 MR. DONALDSON: I would say roughly at
6 least 4,000, 4,500.

7 MR. RICE: What would be the value of this
8 drug inventory?

9 MR. DONALDSON: Roughly between \$6,000.00
10 and \$7,000.00.

11 MR. RICE: Do you find that inventory
12 adequate for the needs?

13 MR. DONALDSON: It depends on the number
14 of prescriptions we fill actually. Our stock moves
15 fairly actively but we are constantly watching our stock
16 and trying to have the manufacturer protect us by
17 replacing it or taking back. There again, we run into
18 a serious problem today in bottles that are opened
19 which we can't return. A great many manufacturers are
20 adopting the attitude today that if they make a
21 statement that they will take back drugs, they want to
22 replace it with other drugs. They will not give us
23 a credit.

24 MR. RICE: Do you have a write-off then
25 for wastage each year?

26 MR. DONALDSON: No, we have no write-off.
27 No, we can't write that off.

28 MR. RICE: You can't charge it up as
29 wastage?

30 MR. DONALDSON: No, we can't.



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2 MR. RICE: Can you give us any estimate
3 as to the value of the drugs wasted each year?

4 MR. DONALDSON: No, I can't, because I
5 never checked it.

6 MR. RICE: In these different types of
7 drugs that you stock, are there a number of those
8 drugs the same drug which is under a different brand
9 or trade name?

10 MR. DONALDSON: Yes, quite a number of
11 duplications or analogs. Analogs are one company will
12 take a drug and change a molecule or something like
13 that and bring it out as another wonder drug, or another
14 drug. I mean it's virtually for the same specific
15 disease.

16 MR. RICE: Could you give us any estimate
17 as to the range of the number of different brand or
18 trade names you may have on some drugs?

19 MR. DONALDSON: I couldn't.

20 MR. RICE: Trade names of certain drugs?

21 MR. DONALDSON: It's quite a bunch,
22 anyway.

23 THE CHAIRMAN: Can you say on any one
24 drug where you have a number of manufacturers' trade
25 names on the same thing on the shelf?

26 MR. DONALDSON: Penicillin would be one.

27 THE CHAIRMAN: How many would you carry
28 of that?

29 MR. DONALDSON: Well that I don't know
30 because as I said in one case where there is one



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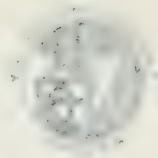
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1
2 manufactured of eight different strengths and we are
3 expected to stock hylenta. The doctor might prescribe
4 it eight different strengths. I will state this: The
5 drug came out in 200,000 units, 250,000 units, 400,000,
6 500,000, 800,000 and a million. Well if a doctor
7 prescribes a 400,000 dose, he certainly doesn't want
8 us to substitute two tablets of 200,000, so to adequately
9 dispense we must stock those various strengths.

10
11
12
13 (page number 1731 follows)
14
15
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17
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30



Donaldson

1729

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(page number 1731 follows)



1
2 MR. RICE: Is there another druggist in
3 your store who works with you?

4 MR. DONALDSON: No, I am working alone.

5 MR. RICE: That would give you very long
6 hours?

7 MR. DONALDSON: Much too long.

8 MR. RICE: Can you give me an approxima-
9 tion?

10 MR. DONALDSON: Taking my weekend call,
11 which we take turns at down there in order to give
12 365 days a year availability, if I get out at the hours
13 we are open, it would be about 70-odd hours. If I am
14 held up, which I am very often till about 10 or 10.30,
15 it means a very long week, something over 80 hours.

16 MR. RICE: And in the weeks you are not
17 on call?

18 MR. DONALDSON: On the store hours alone,
19 52 to 54 hours. 52 I would say right now, but then I
20 have to stay after the store is closed to complete my
21 records, which involves anywhere from three-quarters of
22 an hour to an hour.

23 MR. RICE: Could you give any estimate
24 as to the number of prescriptions that you filled last
25 year?

26 MR. DONALDSON: Very close to 9,000
27 prescriptions.

28 MR. RICE: Could you give us any estimate
29 as to the value of those prescriptions?

30 MR. DONALDSON: Around \$23,000.00,



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1 \$22,000.00 and some odd I believe it was.

2
3 MR. RICE: Could your business exist on
4 the sale of drugs solely?

5 MR. DONALDSON: Working alone it could
6 if I were assured that those prescriptions would come
7 into the store. Pretty well, but it wouldn't give me
8 any more than enough to survive on, because you have to
9 have extra help when you go out for meals, and keeping
10 the store clean and dusted.

11 MR. RICE: Where do you obtain your drugs
12 from, a wholesaler or a manufacturer?

13 MR. DONALDSON: Both wholesaler and direct
14 from the manufacturer.

15 MR. RICE: Are you a member of the Associa-
16 tion?

17 MR. DONALDSON: Yes, the O.R.P.A. I am
18 district representative, and the Canadian Pharmaceutical
19 Association.

20 MR. RICE: Are you a member of the Drug
21 Trading Company?

22 MR. DONALDSON: Yes.

23 MR. RICE: Do you purchase from them as
24 well?

25 MR. DONALDSON: Yes I do.

26 MR. RICE: What prices do you usually
27 purchase at? Is it the usual less 40% of the suggested
28 sale price?

29 MR. DONALDSON: On some items only. That
30 has been reduced considerably in this last while or two.



\$22,000.00 and some odd I believe it was.

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MR. DONALDSON: I think it would.

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MR. DONALDSON: On some items only. That

and some items are sold at a profit of two



1
2 If we buy direct from quite a number of manufacturers
3 we do get 40%. They have reduced their profit to us
4 in the last short time, and it would look as if others
5 are going to follow suit.

6 MR. RICE: Do you ever receive any
7 complaints about the drugs you have dispensed?

8 MR. DONALDSON: In the matter of price?

9 MR. RICE: No, in the matter of quality?

10 MR. DONALDSON: No, we have never had any,
11 because I don't see how there could be a complaint,
12 because the only drugs we stock are those which have
13 been put out by companies which have adequate facilities
14 for providing reliable drugs, and that is the only type
15 we will handle.

16 MR. RICE: Have you had complaints about
17 price?

18 MR. DONALDSON: Very little in Renfrew.

19 MR. RICE: Could you tell us how you set
20 your price for prescriptions in Renfrew in particular?

21 MR. DONALDSON: We adopted the pricing
22 schedule as suggested by the Ontario College of Pharmacy.

23 MR. RICE: Do you follow that schedule?

24 MR. DONALDSON: Pretty much so. We use
25 our judgment. If a person is an old-age pensioner,
26 or in straitened circumstances, we do drop the price
27 in consideration of their position. We do that on our
28 own accord, and not in every case, naturally. We have
29 adopted the schedule in my store because of the fact it
30 is the only assurance I will get a fair return on my

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1
2 investment. The haphazard method we had before was a
3 very poor one.

4 MR. RICE: Was there a local method
5 before?

6 MR. DONALDSON: No, it was just a hit
7 and miss programme.

8 MR. RICE: Do you know if the other
9 stores in the Renfrew area have also adopted the
10 College's method?

11 MR. DONALDSON: I cannot say that they
12 have definitely adopted it. I rather imagine they do,
13 because of the fact we never have a person bring a
14 prescription in and ask us to price it, and then go out
15 and not come back.

16 MR. RICE: There is some indication that
17 one prescription as given to the customer, there is
18 some indication that it is priced by the code on it.
19 Is that practised in Renfrew?

20 MR. DONALDSON: No.

21 MR. RICE: When you give a bill to a
22 customer for the prescription, do you itemize the fee
23 in it, or do you just give a blanket bill?

24 MR. DONALDSON: What was that again?

25 MR. RICE: I understood under the method
26 of the Association they have to start off with a fee.
27 I was wondering if you give an account to a customer,
28 do you itemize the fee and how much for the drug, and
29 so on?

30 MR. DONALDSON: I don't know of any



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because of the fact we never have a person bring a

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and get some back.

MR. RICE: That is very different from

one prescription as given to the customer, there is

some indication that it is priced by the code on it.

Is that practised in Britain?

MR. DONALDSON: Yes.

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customer for the prescription, do you itemize the fee

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2 profession or business who do that.

3 THE CHAIRMAN: He would be a very foolish
4 fellow if he did. The only time that rule of two works,
5 and it is well-known, is in the legal profession. Add
6 \$500.00 and multiply by two or three according to the
7 situation.

8 MR. WREN: And it is rare that you ever
9 show the table.

10 MR. RICE: Have the inspectors from the
11 Ontario College of Pharmacy visited your store?

12 MR. DONALDSON: Yes, oh yes.

13 MR. RICE: Have they discussed any prices
14 with you?

15 MR. DONALDSON: They don't discuss price
16 as a rule. I don't recall at any time that the inspec-
17 tor has discussed prices with me. He has been trying
18 to be of some value and help to us in seeing that our
19 records are properly entered, seeing that we have the
20 schedules we need to provide our own protection so that
21 we will not repeat a prescription that is non-refillable.
22 Things of that nature are usually the case. I have
23 found that to be the case anyway.

24 MR. RICE: The prescriptions that come
25 into your store, are they usually written in generic
26 form, or brand name form?

27 MR. DONALDSON: Usually brand names.
28 Generic names are so unwieldy it is impossible for a
29 doctor to remember them. He would spend too much time
30 writing them in the majority of cases. Sometimes the



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1
2 brand name is bad enough, but a generic name, for
3 instance, Retracto 4, there are four substances in that,
4 and the only generic name applied to that, which is
5 very popular at this time, would be to list those four
6 drugs.

7 MR. RICE: You would have no control over
8 the selection of the manufacturer of the particular
9 drug?

10 MR. DONALDSON: If a doctor prescribes a
11 definite drug, then I must in all duty dispense that
12 drug.

13 MR. RICE: There is no way you could take
14 advantage then of different manufacturers' prices?

15 MR. DONALDSON: No, there is no such a
16 thing as a substitution.

17 THE CHAIRMAN: That was a very interesting
18 story Mr. Donaldson.

19 MR. WHITE: Mr. Donaldson, in your
20 experience, if a generic drug is prescribed, does the
21 druggist feel morally obliged to supply the least
22 expensive brand on his shelf?

23 MR. DONALDSON: No we don't adopt that
24 attitude. I am speaking personally for myself. When
25 we have not had any generic names prescribed, they are
26 all brand names in our part of the country so far. In
27 choosing the drug do you mean if I were filling a
28 prescription would I use a drug of the least cost?

29 MR. WHITE: Yes?

30 MR. DONALDSON: Only if that drug had the



brand name is bad enough, but a generic name, for instance, Reserpine, there are four substances in that, and the only generic name applied to that, which is very popular at this time, would be to list those four

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MR. WHITE: Yes?

MR. DONALDSON: Only if that drug had the



1 same reliability and safety factor to me as the drug
2 of proven merit and in a manufacturer in which I had
3 supreme confidence. If it had the same quality and
4 reliability, naturally I would use it, but only on
5 condition I wouldn't be making myself legally responsible
6 for malpractice.
7

8 MR. WHITE: But you wouldn't have an
9 inferior drug on your shelf?

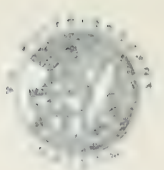
10 MR. DONALDSON: Definitely not.

11 MR. WHITE: I have been told two different
12 things by druggists that I know. If you were to receive
13 a prescription written in generic terms, and let us say
14 you had manufacturer A's product on your shelf and
15 manufacturers B's product on your shelf, they are both
16 of acceptable quality to you, if A were \$5.00 and B were
17 \$4.00, would you feel morally obligated to supply one
18 or the other?

19 MR. DONALDSON: We are just as anxious
20 as the public are to supply medicines at the least cost.
21 It is no feather in our caps to take a prescription out
22 for \$5.00 or \$6.00 or \$8.00. I don't appreciate or
23 get any satisfaction out of that at all, so I would
24 naturally supply the drug if that were of the same
25 reliability at a lower cost.

26 MR. WHITE: I understand your position
27 in this matter. Is this the Code of Ethics of the
28 profession?

29 MR. DONALDSON: Yes, the Code of Ethics
30 of our profession is to dispense only reliable and pure



same reliability and safety factor to me as the drug
of proven merit and in a manufacturer in which I had
supreme confidence. It had the same quality and
reliability, naturally I would use it, but only on
condition I wouldn't be making myself legally responsible
for malpractice.

MR. WHITE: But you wouldn't have an

inferior drug on your shelf?

MR. DONALDSON: Definitely not.

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things by druggists that I know. If you were to receive
a prescription written in generic terms, and let us say

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2 drugs, and that thing I mentioned in the last part of
3 my notes, that the druggist of integrity will only
4 dispense to the public drugs that he would take himself
5 and supply for his family, and I think that is pretty
6 general in the average drugstore in Ontario.

7 MR. WHITE: Do the ethics of the profes-
8 sion compel you to supply brand B in this instance, or
9 is that up to the individual druggist? Do the ethics
10 of the profession compel the druggist to supply the
11 lower cost brand?

12 MR. DONALDSON: No, that is left up to our
13 own discretion.



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2 MR. WHITE: The manager of the Drug Manu-
3 facturers' Association led us to believe that all obso-
4 lete or deteriorated drugs were accepted back from
5 retailers with full credit, but I judged from what you
6 have told us that this isn't exactly the case.

7 MR. DONALDSON: No, it isn't. More and
8 more firms are adopting the attitude today - for
9 instance, if we have a bottle partly filled, if it has
10 been opened at all, the firms will not take them back.
11 There are a great many cases where we have been too
12 busy to check our stocks of drugs, and they may be a
13 year or two old and they refuse to take them back.

14 MR. WHITE: Even full bottles?

15 MR. DONALDSON: Even full bottles. More
16 and more firms are demanding - not demanding but forcing
17 us to accept drugs in place of those returned, and they
18 will not issue a credit to us, which is the only business-
19 like practice. But they want us to take drugs in place
20 of those. It is not increasing our inventory. If we
21 have not used them we have to replace those with others
22 and still increase our stocks. So it has got to be
23 quite a problem.

24 THE CHAIRMAN: I wonder if this doesn't
25 revolve around the interpretation of what a credit is.
26 What is a credit? Is it a credit whereby whatever is
27 returnable must be replaced at that time with other
28 drugs or goods of equal value?

29 MR. DONALDSON: Yes, that is virtually
30 what it is.

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what it is.



1
2 THE CHAIRMAN: Whereas someone else
3 might say: "If they are returnable I will accept a
4 credit on my account which I will use up in my purchase
5 of drugs at a later date".

6 MR. DONALDSON: Yes.

7 THE CHAIRMAN: Is that the practice you
8 are talking about?

9 MR. DONALDSON: Yes.

10 MR. WHITE: I got the impression, Mr.
11 Chairman, from the drug manufacturers that they accepted
12 back any drugs, whether they were opened or not, whether
13 they were deteriorated or not, and this was one reason
14 why the drug cost was so high, because of this particular
15 expense.

16 THE CHAIRMAN: Yes.

17 MR. WHITE: If you had any accounts you
18 did write off, that would be considered an expense in
19 the business.

20 MR. DONALDSON: You can't write them off.
21 I don't know how you would handle it. I would like to
22 find that one out.

23 MR. WHITE: You said you dispense 9,000
24 prescriptions and the gross value is about \$23,000.
25 This Committee has heard the suggestion that pharmacists
26 might be well-advised to sell drugs at their cost and
27 add a dispensing fee of two or three dollars. Do you
28 think yourself this would be a good method of distri-
29 buting drugs?

30 MR. DONALDSON: I definitely think we

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THE CHAIRMAN: Whereas someone else



1 should have a dispensing fee. Our commitments are so
2 expensive today we cannot work under the cost of some
3 drugs. We have to have a minimum of 40% and a dispen-
4 sing fee, which is 75 cents now. It has been a sugges-
5 tion that that is a fee to adopt, but that is not enough.
6

7 MR. WHITE: Do you think yourself the
8 profession would be well-advised to sell drugs at cost
9 plus a somewhat larger dispensing fee?

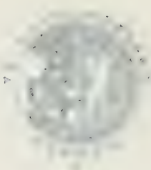
10 MR. DONALDSON: Absolutely, if that fee
11 guaranteed us the necessary profit. I would say that
12 would be a very good way of handling it.

13 MR. WHITE: Do you happen to know the
14 feeling of your Association on that subject?

15 MR. DONALDSON: I have never discussed it
16 with them.

17 MR. WHITE: It was mentioned in the
18 questioning by Mr. Rice that you are a member of the
19 Drug Trading Company. Can you explain that?

20 MR. DONALDSON: Well, the Drug Trading
21 Company was a company formed some years ago by a number
22 of pharmacists to get together so that they could take
23 advantage of deals and larger quantities. They divided
24 the amount of purchase that came in between themselves.
25 For instance, they might need three dozen Eno's Fruit
26 Salts. If they bought half-a-dozen there wouldn't be
27 any extra discount. Usually in quantity buying you
28 get the discount, and it started in that way and it has
29 been increased, and it one of the salvations of the
30 drug business and without it I don't know how we would



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1 operate today.

2
3 MR. WHITE: Is it a limited company or
4 co-operative?

5 MR. DONALDSON: It is a co-operative
6 company.

7 MR. WHITE: Are the profits distributed
8 to the members each year?

9 MR. DONALDSON: Yes.

10 MR. WHITE: Based on their percentage of
11 purchases?

12 MR. DONALDSON: Yes.

13 MR. WHITE: What would that be? Would it
14 be 5% of your purchases?

15 MR. DONALDSON: I don't recall now.

16 MR. WHITE: We were told by the Chief
17 Inspector of the College of Pharmacy that he did on
18 occasion discuss prices with the pharmacists; sometimes
19 he might point out the prices were too high or too low. Has
20 he had occasion to discuss prices with you in that
21 manner?

22 MR. DONALDSON: No, he hasn't. I don't
23 understand him at all on that point.

24 MR. WHITE: If the doctors find it diffi-
25 cult to prescribe by a generic name because those
26 generic names are so much longer than the brand names,
27 couldn't there be a cross-reference index established
28 so that brands such-and-such could be translated into
29 the generic term reasonably? I cannot see that that is
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1
2 MR. DONALDSON: With 540 products coming
3 out every year I think it would be a difficult job for
4 a doctor to go through the cross index to find the
5 generic names. It would be a pretty difficult task.
6 I don't think it could be handled.

7 MR. WHITE: You mentioned 500 new drugs
8 earlier. What portion of those 500 new drugs do you
9 yourself stock?

10 MR. DONALDSON: I don't know. I haven't
11 any figures for that.

12 MR. WHITE: You wouldn't stock each of
13 the 500 new drugs?

14 MR. DONALDSON: No, a proportion of them.
15 It would depend on the locality a good deal and what is
16 going at the present time, what we might think the
17 doctors in our locality might choose. For instance, we
18 might have an illness calling for a diurectic; naturally
19 we would buy that. But if the manufacturer brought out
20 a drug for mountain fever and tried to sell that, we
21 wouldn't have anything to do with that.

22 MR. WHITE: Of the 500 new drugs, might
23 you stock 50 or 10 or 100?

24 MR. DONALDSON: 50 - no, I would say a
25 100 or more.

26 MR. WHITE: You mentioned four or five
27 different sets of record books that you are required to
28 keep. Do you feel all those are necessary?

29 MR. DONALDSON: Oh, yes. Boy, if they
30 weren't I wouldn't be keeping them.

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2 MR. WHITE: You mentioned that 70% of
3 doctors' prescriptions couldn't legally be filled without
4 having a prescription issued.

5 MR. DONALDSON: That is from my store.
6 That is not an Ontario survey.

7 MR. WHITE: Do you think that more pres-
8 criptions should be automatically repeatable at the
9 patient's request?

10 MR. DONALDSON: No, because that 70%
11 includes all the drugs such as sedatives, hypnotics,
12 diuretics, narcotics, all those that the public should
13 not be permitted to use on their own.

14 MR. WHITE: Is it more expensive for you
15 to dispense a new prescription than a repeat prescrip-
16 tion?

17 MR. DONALDSON: Again it would depend -
18 if we have a new prescription - I would love to have
19 that prescription repeated I mentioned about the tranca-
20 pol. It doesn't cost us any more to repeat a prescrip-
21 tion.

22 MR. WHITE: So there are some economics
23 in repeat prescriptions.

24 MR. DONALDSON: Yes. It could prove
25 beneficial to our problem.

26 MR. WHITE: That concludes my questions.
27 Thank you.

28 MR. WREN: Mr. Donaldson, I have been
29 very impressed since this Committee started with the
30 thoroughness and quality of training that pharmacists

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MR. WHITE: Mr. Donaldson, I have been

very impressed since this Committee started with the

thoroughness and quality of training that pharmacists



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2 receive. I would say it is a very highly qualified
3 profession. Following Mr. White's questioning, I am
4 wondering what your opinion is due to the inability of
5 your profession to attract a sufficient number of
6 recruits. Would it be your personal opinion that it
7 would be better to accept a higher fee on a professional
8 basis for the work you do, the important work you do,
9 and then get out of the department store business?

10 MR. DONALDSON: If we could get out of
11 the department-type of business, that's fine. I don't
12 think there are too many of us that wouldn't like to
13 get out of that end of it. You mean just to have
14 straight dispensaries?

15 MR. WREN: Yes.

16 MR. DONALDSON: I don't think it is
17 practical.

18 MR. WREN: I am concerned personally
19 with your ability to recruit a sufficient number of
20 replacements of those who retired, and so on. How else
21 are you going to recruit them unless you enhance the
22 professional aspects of your practice? In other words,
23 doctors confine themselves to the practise of their
24 profession, they don't have any sidelines in their own
25 office. It seems to me you would enhance the status
26 and prestige of your profession.

27 MR. DONALDSON: If we don't find any
28 solution of it in a short time it is going to be a very
29 serious matter, and I say that in all sincerity,
30 because I feel today that my services in my community



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2 are very valuable. I have always been proud of my
3 profession, I have been proud of the work I am doing
4 and I have been proud of the place I have taken in the
5 community in the health field. But I feel if those
6 services are reduced very much more it could be rather
7 a nasty matter for the public.

8 MR. WREN: In my case, I come from an
9 area which has smaller towns than the one you live in,
10 and I have examples that it is necessary in many cases
11 that the department store aspect of your business has
12 to subsidize the dispensary. If that follows through,
13 if you can't subsidize your dispensary, a lot of communi-
14 ties are going to be without your ability.

15 MR. DONALDSON: One of the things that has
16 bothered me is the inroad of these things into outlets
17 which are not drug outlets. For instance, first aid
18 supplies in grocers: you naturally assume that the
19 drugstore is the first place for first aid supplies.
20 Grocers are putting these things in, and every time
21 they sell one of them the drugstore sells less.

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1
2 THE CHAIRMAN: Just stop for a second,
3 Mr. Donaldson, when these first aid packages are sold
4 how would the vendor know about the deterioration or
5 the age of the package or shelf life?

6 MR. DONALDSON: They have no idea of
7 that at all, absolutely none. They don't know the
8 difference between a plain band-aid and a mercurochrome
9 band-aid. They don't know the difference of types of
10 bandages or adhesives that are being handled.

11 THE CHAIRMAN: Nor do they know about the
12 various purposes for which the first aid might be
13 required?

14 MR. DONALDSON: They have no training at
15 all. Does that answer your question?

16 MR. WREN: Pretty generally, but my
17 concern is - there is no doubt in our minds that the
18 professional services of the pharmacist are vital to
19 our general health scheme. If they are not going to be
20 able to recruit young people to go into the profession
21 due to the fact they are not, shall we say, operating
22 on a professional basis in the broad sense, we have to
23 do something about it.

24 MR. DONALDSON: I think, and I am speaking
25 for myself, in my own opinion I feel quite sure that if
26 all products connected with health and the body were
27 left in the druggist's hands to sell there would be a
28 little different picture. Today you can buy camphorated
29 oil - that is a dangerous drug. You can buy boracic acid
30 of which you have heard so much, in any type of store.

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3 were drug products and our Pharmacy Act were of such a
4 type to protect us in the sale of those, I see no
5 reason why we couldn't increase our returns and have a
6 better picture.

7 MR. RICE: Could you tell us how many
8 square feet you have in your store?

9 MR. DONALDSON: Pardon?

10 MR. RICE: How many square feet are there
11 in your store?

12 MR. DONALDSON: In the store itself?

13 MR. RICE: In your business.

14 MR. DONALDSON: Our store is 22 by say,
15 about 50.

16 MR. RICE: How much of that would be taken
17 up with a dispensary?

18 MR. DONALDSON: About 20 by 18, that is
19 just in the dispensary itself. I have to use the back
20 part for extra stock.

21 MR. RICE: Do you rent your store?

22 MR. DONALDSON: Yes, I rent.

23 MR. RICE: Could you tell us what rent
24 you pay for your store?

25 MR. DONALDSON: \$100 a month. I heat it
26 myself and I do all my own repairs.

27 MR. RICE: Thank you.

28 MR. TROTTER: Mr. Donaldson, how often
29 does the inspector call?

30 THE CHAIRMAN: This was dealt with before



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MR. DONALDSON: Now, Mr. Chairman, does the inspector call?

THE CHAIRMAN: This was dealt with before



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2 you arrived.

3 MR. TROTTER: I don't think he told us
4 how often the inspector came. I was here when he was
5 talking about inspections, but I don't think he said
6 how often.

7 MR. DONALDSON: I would say roughly, at
8 least once a year or maybe once every eight or ten
9 months. I think it is somewhere in there.

10 MR. WHITNEY: I wonder if I could ask a
11 question or two. In discussing the number of hours
12 that a druggist or pharmacist has to work, Mr. Donaldson:
13 I know a city of approximately 20,000 people. I believe
14 they have approximately eight or nine drugstores there
15 and they have an arrangement among all druggists that
16 the different stores - there is only one store open in
17 the evening and that is open from about 6 to 8 o'clock
18 or 9 o'clock at the latest and also on Wednesday after-
19 noons there is one drugstore open, and likewise on
20 Sundays. The thought entered my mind where there is
21 only one person, one pharmacist who is the proprietor
22 in the drugstore and he takes off an hour or two hours,
23 perhaps to attend a Service Club luncheon or something
24 of that kind, and the sales go on of a great many items -
25 of course, prescriptions couldn't be filled - at the
26 same time where there are such long hours, long periods
27 of time, is it actually the drug business that is
28 keeping them open or the other line of business, the
29 lunch counter or soda fountain, that is actually causing
30 these stores to be open all the time?

You arrived.

MR. THORNTON: I don't think he told us

how often the inspector came, I was here when he was

asking about inspections, but I don't think he said

how often.

MR. DONALDSON: I would say roughly, at

least once a year or maybe once every eight or ten

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MR. WHITNEY: I wonder if I could ask a

question or two. In discussing the number of hours

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I know a city of approximately 30,000 people. I believe

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2 MR. DONALDSON: When I was quoting
3 figures from Renfrew, for Renfrew only, those are
4 definite figures. How they would apply to other loca-
5 tions, I am not too sure. I know of some cases where
6 a store has a very small prescription business and the
7 pharmacist does not have to be in the store all the
8 time. He is leaving himself legally open for not being
9 there. When drugs are sold over the counter our Pharmacy
10 Act insists that a druggist be in charge of the store
11 at all times.

12 MR. WREN: How many so-called patents
13 would it be wise for a pharmacist to look at before he
14 gave it to the customer?

15 MR. DONALDSON: I beg your pardon?

16 MR. WREN: How many so-called patent
17 medicines are there where it would be wise that a phar-
18 macist sold them directly to the consumer? In other
19 words, are there any of the patent medicines that are
20 dangerous and could be dangerous?

21 MR. DONALDSON: Yes, there are, aspirin
22 for instance. Aspirin is a dangerous drug if handled
23 in unskilled hands. We have heard of a number of babies
24 having died. You have seen occasionally where a baby
25 died from an overdose of aspirin. These are sold
26 indiscriminately. Boracic acid is another, but how
27 many of that type of thing, you ask, are sold outside
28 a drugstore?

29 MR. WREN: No, in the drugstore; what I
30 mean, does the pharmacist in selling directly casually



MR. HOWATSON: When I was creating

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dying from an overdose of aspirin. These are sold

indiscriminately. Barbitic acid is another, but how

many of that type of thing, you ask, are sold outside

of drugstores?

MR. WILSON: No, in the drugstore; what I

want to know is whether or not they are sold outside



1
2 enquire what they are going to use it for so if there
3 was any potential danger, to warn them, whereas an
4 ordinary clerk wouldn't know the difference.

5 MR. DONALDSON: Well, in some respects
6 they wouldn't know what it was for. I find in my store
7 we have a pretty good idea, about 75 or 80% of what
8 the drug is going to be used for.

9 THE CHAIRMAN: I remember a case where
10 somebody got injured with a butcher knife or a meat
11 carving knife and apparently they thought they should
12 institute an action against the hardware store that
13 sold the knife.

14 MR. DONALDSON: Sold what?

15 THE CHAIRMAN: The knife. I don't know
16 where you start or stop that sort of thing.

17 MR. WREN: My point was not legal liability,
18 my point was the desirability of having a pharmacist
19 supervise so these accidents couldn't happen.

20 MR. DONALDSON: Our legal liability could
21 be carried to this extent: if a customer came into the
22 store and asked for a bottle of olive oil and the clerk
23 gave camphorated oil instead, and the customer took it
24 home and took the camphorated oil he would naturally
25 suffer some very serious consequences. We are legally
26 liable so we try to make sure it doesn't happen.

27 MR. WHITNEY: Isn't it true that the
28 farmers or agricultural people who make purchases of
29 farm medicine for animals and so on feel if they go to
30 a drugstore they are purchasing a packaged article from



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2 a clerk who perhaps is not any more qualified, a sales-
3 clerk, to discuss the matter with them than the feed
4 dealer who is exclusively interested in animals rather
5 than other things generally. I am not referring to
6 things that are not of patented nature or anything of
7 that kind. Is it not true in a drugstore it is often
8 a girl clerk who does not know very little of the prac-
9 tical use or the way that dosage should be given, whereas
10 in the feed store they have an active interest - isn't
11 that the reason why more medicine of that type for
12 animals is being sold from feed stores?

13 MR. DONALDSON: I don't think that
14 applies because if a farmer comes in and he wants some
15 product for fodder or some such thing or if he wants to
16 give an injection of penicillin, no clerk has the
17 knowledge in the store to handle that. It is all right
18 if he wants a remedy for kennel spasms, which is a counter
19 item, as we call it. Antibiotics are kept in the dispen-
20 sary and the clerks don't go into the dispensary. That
21 is in the stores I am familiar with, with the others
22 I am not prepared to say.

23 MR. WHITNEY: Thank you.

24 MR. DONALDSON: We take the attitude any
25 antibiotic, which is a drug, aureomycin, are restricted
26 drugs and my clerks never go near them.

27 MR. SUTTON: In the treatment of mastitis
28 and so on wouldn't the veterinarian give the prescrip-
29 tion and they would automatically go to the drugstore?

30 MR. DONALDSON: Some of the feed dealers



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2 are handling those items themselves. It was on the
3 restricted list up until a short time ago.

4 MR. SUTTON: Could they get them through
5 the feed store?

6 MR. DONALDSON: They could get it through
7 the feed.

8 MR. SUTTON: Without a prescription?

9 MR. DONALDSON: Without a prescription.
10 They can get supplementary feeding with antibiotics in
11 them there. I am not too familiar with this, but I
12 think I am on the right ground that they could have
13 serious effects. I cannot substantiate this, but I do
14 know one pharmacist told me a story where they were
15 feeding chicks a certain type of antibiotic to increase
16 its growth and increase the rapidity of its growth and
17 they found on investigation that there was some question
18 of the chicks' reliability or quality of product after-
19 ward. They felt - I shouldn't possibly mention that
20 because I couldn't substantiate it. I know that is one
21 story and this pharmacist was advising this customer not
22 to use it, but that particular product, I believe, was
23 being sold indiscriminately in feed stores.

24 MR. PRICE: Would there have been any
25 danger involved?

26 MR. DONALDSON: It hadn't been proven.
27 The investigation hadn't gone far enough, but there was some
28 danger involved, I believe. They were investigating it.
29 I haven't heard whether they finished or not. There was
30 a definite strain in the chick that was not regular.



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2 THE CHAIRMAN: Doesn't all this point to
3 the redundancy, where some items can be bought without
4 professional persons in attendance while if one drug-
5 store is in operation even though it didn't sell one
6 medicine a day, the very fact it is a drugstore with a
7 one-man operator, to conform with the law he must bring
8 his lunch and before he rents the premises make sure
9 there is a toilet or some washing facilities installed
10 in the leased premises - is that about the position?

11 MR. DONALDSON: Yes, about.

12 THE CHAIRMAN: So to go home for lunch,
13 to leave the premises for any purposes, you have
14 committed a breach of the Act?

15 MR. DONALDSON: You are not permitted to
16 leave the premises.

17 THE CHAIRMAN: That is what I mean, you
18 have committed a breach of the Act?

19 MR. DONALDSON: That is right.

20 THE CHAIRMAN: I think that is the
21 situation. That has to be related back to the sale of
22 these products through other outlets, having in mind
23 the protection of the public.

24 Are there any other questions?

25 MR. BOYER: In connection with the Drug
26 Trading Company, is it possible to secure quantity
27 discount on drugs - you mentioned, I think, some one
28 product, Eno's Fruit Salts?

29 MR. DONALDSON: That is only from the
30 manufacturers - I mean if the manufacturer sets the



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 professional persons in attendance while in one drug-
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MR. BOYER: In connection with the Drug
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 discounts or other benefits, I would like to
 know, would you please answer?

MR. DONALDSON: That is only from the
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MR. BOYER: You see, what I was asking was about drugs. Does the Drug Trading Company make arrangements with suppliers to give them a quantity discount on drugs?

MR. DONALDSON: I don't know anything about that.

MR. BOYER: That is something that we might perhaps enquire into Mr. Chairman at a later time. I take it that the purpose of the Drug Trading Company in the first place was to endeavour to reduce drug prices, is that correct?

MR. DONALDSON: Yes.

THE CHAIRMAN: Mr. Donaldson thank you very much. We appreciate it very much and we also appreciate your frank and forthright presentation of the information which you have. I hope that this attendance has not inconvenienced you too much.

MR. DONALDSON: Thank you Mr. Chairman.

MR. ROBERTSON: Now Mr. Chairman we have here Mr. Turner of London. I understand the Committee wanted to hear from druggists operating various sizes of communities.

SUBMISSION BY

MR. S. G. TURNER, Phm.B.

Retail druggist of London, Ontario

MR. TURNER: Mr. Chairman, gentlemen, the submission I have, although I have some notes here with me will be more or less of an oral submission.

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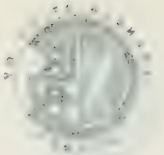
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As you know, my names is Mr. Turner.
I graduated from the College of Pharmacy in 1933. For
the past 24 years I have been operating a drug store
in London, Ontario. My drug store is situated in the
heart of a residential area, covering a population of
between 2,500 and 3,000 homes.

We are situated by ourselves. There are
no other shopping centres in the vicinity. The next
nearest drug store is probably eight to ten blocks
away. There are no variety stores situated near us
within five or six blocks and so our location -- it's
in a restricted area. It's now restricted and we have
become more or less of a focal point for that particular
area.

The residents of the community I would
consider to be people of average circumstances, com-
prising for the most part office people, executives,
salesmen, small percentage of who might be factory
workers. In short, we do business with people that we
would probably consider white collar workers. I think,
therefore, that our trade can be considered to be of
an average type people of all ages, families of all
sizes and of average age.

We are situated a block from a public and
secondary school and therefore have contact with many
younger people. I think in all our operation might
be comparable to any strictly community operation. Our
drug store there is and has been for the last 24 years
a service centre of our community. During this period



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We are situated by ourselves. There are no other shopping centres in the vicinity. The next nearest drug store is probably eight to ten blocks away. There are no variety stores situated near us within five or six blocks and our location is in a restricted area. It's now restricted and we have become more or less of a focal point for that particular area.

The residents of the community I would consider is made up of people of various backgrounds,prising for the most part office people, executives, salesmen, small percentage of who might be factory workers. In short, we do business with people that we would probably consider white collar workers. I think, therefore, that our trade can be considered to be of an average type people of all ages, families of all sizes and of average age.

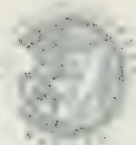
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2 of time the same little services, same small advices,
3 same words of comfort and encouragement and the same
4 enquiring telephone calls that we encounter every day,
5 same advices on how to give the children's medicine and
6 what we will do for Johnny's scraped knee, same advices
7 that we gave some parents 25 years ago, we are now
8 giving to their children who are raising families of
9 their own.

10 To me it's very gratifying to find that
11 people have trusted our judgment over the years on so
12 many things and we are most happy to supply these
13 services when asked to give them. I think there is not
14 a doubt in the world ~~what~~ a drug store in a community
15 of this type, with the small problems that arise and
16 are handled by the local druggist, mostly take from the
17 physician in a community area like that, take away from
18 them a lot of useless calls and we have always tried
19 to give advice to these people; tried to find out their
20 troubles and if we think that they should be directed
21 to a physician, then we do so. If it is some minor
22 thing we can help them with, we are only too glad to do
23 it.

24 I do think we have carried a responsibility
25 in that regard in our community over these years, and
26 I think that our community is happy that we have been
27 there and I think they are proud of us. The druggist
28 in a community is equipped to render this advisory
29 service and are doing it and as I said we are proud of
30 the record we have in our community. We have contributed



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2 something to its welfare.

3 We have, on numerous occasions, spoken
4 to local groups such as church groups, parent-teachers
5 association on problems of health, potential medical
6 hazards in the home, potential poisons in the home,
7 the control of poison in the home and many topics
8 related to public health and this has been very well
9 received and I think we have served a useful purpose.

10 Our store operates twelve hours a day
11 from 9 a.m. until 9 p.m. at night and it is always under
12 the supervision of a registered pharmacist. We used to
13 open every Sunday from twelve until six. In the last
14 couple of years we have come to an arrangement in
15 London. We have a Sunday rotation schedule that now
16 we are open once every eight weeks which leaves two
17 stores in each area open for service to the public
18 and on this basis instead of opening from twelve to
19 six we open at ten in the morning until six at night.

20 We do in our store, of course, sell patent
21 medicines, cosmetics, tobacco and sundries, ice cream,
22 soft drinks and stationery, candy, chocolates, magazines.
23 We do this because we feel that this is a service to
24 our community and the people expect that we should have
25 them and so we carry them. This does entail, of course,
26 substantial amount of help in what we call our front
27 store operation. We employ three full-time clerks and
28 one part-time clerk in the front. As I said, I, myself,
29 and I have a registered pharmacist on duty, either
30 myself or him at all times. There are two registered



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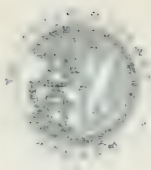


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2 pharmacists employed by the store. Our dispensary is
3 well stocked. It comprises a little over ten per cent
4 of our total. It is clean, painted white, hot and cold
5 running water. The dispensary is an open type. We
6 carry twenty-one hundred and some odd prescription items
7 in our dispensary and except for very rare occasions
8 we can fill almost any prescription that comes into our
9 store.

10 In our district we have five general
11 practitioners within an area of ten or twelve blocks
12 and two specialists. I think all of the general
13 practitioners carry some degree of partial dispensing
14 service in their office, and we have two dentists.

15 We have always operated our store on the
16 assumption that the public puts its trust in our
17 judgment and therefore have never offered for sale any
18 drugs whether bulk or compound drugs, whether they be
19 household drugs and I am speaking of Boracic Acid and
20 that type of thing, Cascara, Witch Hazel unless we
21 are absolutely sure that the sources from which we
22 bought them were without question. We can on numerous
23 occasions make more money on products of certain
24 manufacture but we have tried to build our business
25 on a solid foundation and I think the results of our
26 operation over the years, the fact that people have
27 accepted our judgment has been well borne out by the
28 fact that we have always made quality the first
29 consideration in our operation.
30

There has been some suggestion of generic



pharmacists employed by the store. Our dispensary is well stocked. It comprises a little over ten per cent of our total. It is clean, painted white, hot and cold running water. The dispensary is an open type. We carry twenty-one hundred and some odd prescription items in our dispensary and except for very rare occasions we can fill almost any prescription that comes into our store.

In our district we have five general practitioners within an area of ten or twelve blocks and two specialists. I think all of the general practitioners carry some degree of partial dispensing service in their office, and we have two dentists. We have always operated our store on the assumption that the public puts its trust in our judgment and therefore have never offered for sale any drugs whether bulk or compound drugs, whether they be household drugs and I am speaking of Boracic Acid and that type of thing, Cascara, Witch Hazel unless we are absolutely sure that the sources from which we bought them were without question. We can on numerous occasions make more money on products of certain manufacture but we have tried to build our business on a solid foundation and I think the results of our operation over the years, the fact that people have accepted our judgment has been well borne out by the fact that we have always made quality the first consideration in our operation.

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2 drugs and price of generic drugs against trade name
3 drugs. In our dispensary operation we do have a certain
4 amount of prescriptions that are prescribed under the
5 so-called generic names. Some of our doctors in
6 London use generic names but on all of these occasions
7 the quality of the product comes first. If two prices
8 are different, providing that we are sure the quality
9 is the same, we most usually use the one of the lesser
10 cost.

11 Over the past ten years -- ten years ago
12 our total sales were \$68,000.00. Last year our sales
13 were \$129,000.00. The net profit on my operation ten
2 14 years ago was 6.8% of my total sales. My profit last
15 year was 6.4% of my total sales.

16 THE CHAIRMAN: Do you deduct anything
17 for your wages as a pharmacist before you compute that?

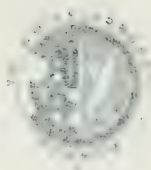
18 MR. TURNER: The 6.8% is everything that
19 I took out of the operation of my store.

20 THE CHAIRMAN: Ten years ago you made
21 \$4,500.00 -- \$4,700.00, whatever it works out to?

22 MR. TURNER: My figures which I have are
23 around \$4,390.00 and last year on my wages that I took
24 from my store, that is on everything, the net profit
25 on that which I consider everything that I took in the
26 way of profit from the store was \$6,995.00.

27 THE CHAIRMAN: What education did you
28 have before you went with the College of Pharmacy?

29 MR. TURNER: I had senior matriculation.
30 That is Grade 13.



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2 THE CHAIRMAN: Senior matriculation.

3 MR. TURNER: At that time I served three
4 years apprenticeship.

5 THE CHAIRMAN: Plus how much?

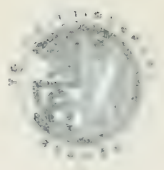
6 MR. TURNER: Plus two years in College.

7 THE CHAIRMAN: So senior matriculation,
8 two years at the College of Pharmacy, three years
9 apprenticeship and getting into this business led you
10 to the result of \$4,300.00 earnings?

11 MR. TURNER: Yes, I might make a comment
12 there. The first year I was in business, which was
13 1937 I made \$21,700.00. On this operation my inventory
14 last year was \$22,000.00 some odd dollars. In my
15 dispensary operation my prescription volume last year
16 was \$28,840.00. We dispense on an average between
17 30 and 35 prescriptions a day and on my dispensary
18 operation the dispensing of that number of prescriptions
19 a day is about all one pharmacist can do -- to fill 35
20 prescriptions a day if he is there all the time.

21 On many of the P.R. prescriptions which
22 are scheduled drugs if you get an occasion, or request
23 to repeat a prescription you must first contact the
24 doctor to get his permission to repeat it unless he
25 has so given that on the prescription to repeat two
26 or three times and I find it takes out of an afternoon's
27 operation about three-quarters of an hour just making
28 phone calls to get permission to repeat the prescription.

29 Taking these things into consideration,
30 the factor of getting the permission to get the



THE CHAIRMAN: Now, Mr. Turner,

MR. TURNER: At that time I served three

years apprenticeship.

THE CHAIRMAN: Plus how much?

MR. TURNER: Plus two years in College.

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two years at the College of Pharmacy, three years

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MR. TURNER: Yes, I might make a comment

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1937 I made \$2,700.00. On this operation my inventory

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1 prescription filled, the prescription recording it --
2 which we do on a locative system under the patient's
3 name. We record every prescription that is filled,
4 new or repeat each day. By the time those operations
5 are taken care of, this means that one druggist working
6 full-time cannot dispense more than six prescriptions
7 an hour and those are prescriptions which would have
8 to be mostly tablets or liquids. If you get into the
9 problem of **slaving** ointment very often you will spend
10 fifteen, twenty, or twenty-five minutes making up a
11 compound and so we figure that six prescriptions an
12 hour for one man is all he can do and thirty-five a
13 day is about the limit. So in setting up the cost, I
14 worked out the cost of my dispensary operation set up,
15 I allotted four-fifths of my druggist's time to the
16 dispensary and four-fifths of my own time. Very few
17 days we would spend two hours in the front part of our
18 store waiting on the front shop customers.
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2 On that basis, charging \$5,656.00 to a
3 pharmacist's wages, and the proprietor's proportion,
4 \$5,000.00, the proportion of the overhead of the total
5 store operations, your rent, your lights, delivery,
6 advertising, is \$1,600.00, and your depreciation, now,
7 I do charge depreciation on my dispensary, because every
8 year we have to throw out several articles, and I charge
9 that as depreciation, the total cost of operating the
10 dispensary is \$13,118.00, and the gross is \$14,420.00,
11 which left us a net profit on a \$28,000.00 dispensary
12 business, or practically \$29,000.00, of \$1,302.00, and
13 that is approximately \$4.03 a day profit that we
14 realize on dispensary operation. Proportion of my
15 dispensary profit to my front store profit. My dis-
16 pensary paid a proportion of the overall profit of
17 about 2.6% to the approximately 7% of our total profit
18 for the operation of the store.

19 MR. SUTTON: A capital of \$22,000.00,
20 is that a borrowed capital, 6% on that too?

21 MR. TURNER: A certain proportion of it
22 is borrowed.

23 THE CHAIRMAN: When you get into that
24 discussion, whether it is borrowed or not it is worth
25 something.

26 MR. SUTTON: The time consuming element
27 in phoning the doctors to get their approval to repeat.
28 Is there any subsequent confirmation in letter form
29 from the doctor, or is that all that is necessary?

30 MR. TURNER: On straight narcotic type



On that basis, charging \$5,656.00 to a pharmacist's wages, and the proprietor's proportion, \$5,000.00, the proportion of the overhead of the total store operations, your rent, your lights, delivery, advertising, is \$1,600.00, and your depreciation, now, I do charge depreciation on my dispensary, because every year we have to throw out several articles, and I charge that as depreciation, the total cost of operating the dispensary is \$13,118.00, and the gross is \$14,420.00, which left us a net profit on a \$28,000.00 dispensary business, or practically \$29,000.00, of \$1,302.00, and that is approximately \$4.03 a day profit that we realize on dispensary operation. Proportion of my dispensary profit to my front store profit. My dispensary paid a proportion of the overall profit of about 2.6% to the approximately 7% of our total profit for the operation of the store.

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2 prescriptions you must have a written signature, but
3 on schedule F prescriptions you must have his permission
4 to refill that prescription.

5 MR. SUTTON: Send a runner over to get
6 a new prescription?

7 MR. TURNER: You can take that prescription
8 over the telephone, but you must have that permission.

9 Breaking down the cost of my dispensary,
10 I found the overhead of the dispensary is \$3.65 per
11 hour.

12 For every clerk employed in the store
13 it is necessary to return that 7% profit to the owner.
14 It is necessary for that clerk to be responsible for
15 \$25,000.00 turnover to give that much profit, and that
16 is not considering any interest on your investment.
17 My total dispensary stock for the year 1960 was
18 \$9,120.00.

19 I say here the gross profit on the
20 operation of a community drug store is hampered by the
21 sale of tobacco and allied lines of small profit. We
22 must keep people available in the store and try to
23 employ a better class of clerk and we try to train them
24 and equip them to answer questions intelligently. Most
25 of our people are well versed on first aid requirements.
26 Anything to do with the dispensary or poisons of course
27 is referred to the druggist, but we employ a little
28 better than average type of clerk to give that service,
29 and of course those people are involved in sales of,
30 as I say, in our community of tobacco and allied lines

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2 of small profit, which shows a fairly large turnover,
3 but your gross profit is down. To properly service
4 the customer, it is necessary to probably overstaff the
5 front store, so that reasonable service can be given in
6 rush hours. The demand for delivery of small items
7 makes it necessary to maintain adequate delivery service,
8 and although probably unnecessary in many cases this
9 has become a matter of public demand over the years.
10 We most truly are asked for service that is expected
11 of no other business, nor is given in any other business.
12 The fact that we as community druggists have been so
13 willing to give of our time and services over the years
14 that the public are virtually horrified if it is refused,
15 we are dependent on the public for their patronage, we
16 are dependent on the physician for dispensing, we
17 cannot promote business in our dispensaries, we must
18 wait until that service is needed, we must always be
19 prepared to have that service available. We must be
20 alert to new study of recent trends in medicine, we
21 must at all times be intelligently prepared to give
22 information to the physician on dosage and strength.
23 And very often during the course of the day the
24 physician will call and ask about a new product, what
25 strength it comes in, and what dosage, and we maintain
26 an up-to-date library on the subject.

27 I finish by saying my 25 years in
28 business have given me many rewards, because it is
29 my feeling that I have contributed something to our
30 community, from the standpoint of financial remuneration



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2 per hour worked, I find that it has been lacking.

3 MR. RICE: With regard to prescription
4 pricing, is there any method or formula or tariff
5 that you follow?

6 MR. TURNER: Yes there is.

7 MR. RICE: Could you tell us what that
8 is?

9 MR. TURNER: It is a method that our
10 association in London have worked out. It is based
11 on the breakdown formula of a 60% breakdown, I am talking
12 from hundred price to fifty to twenty-five to twelve.
13 It is a 60% breakdown formula, plus a dispensing fee
14 of fifty cents, is what we use in London. That is not
15 everybody does not use it, I think the majority. There
16 are two or three different methods being used in
17 London as a matter of fact.

18 MR. RICE: You don't use the College's
19 method of estimating?

20 MR. TURNER: We don't in our store. I
21 understand that it is being used in London in some
22 cases.

23 MR. RICE: But your fee is set at a
24 certain percentage of the cost, plus a dispensing
25 fee?

26 MR. TURNER: That is right. Not of the
27 cost of the, do you mean --

28 MR. RICE: The cost to you, does the
29 manufacturer supply you with a sale price?

30 MR. TURNER: They have a catalogue.



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2 MR. RICE: That is the price you go by
3 for your 60%?

4 MR. TURNER: That is right.

5 MR. FULLERTON: It has been mentioned
6 that \$125.00 was the salary for one assistant pharmacist.
7 Would that be the average salary across the province
8 approximately?

9 MR. TURNER: I think \$125.00 would be
10 average. Actually, I pay my pharmacist \$136.00. I think
11 in London, I don't know about across the province, I
12 think in London it runs from \$120.00 to \$135.00.

13 MR. FULLERTON: It has been mentioned
14 about the decline of students entering College to study
15 pharmacy. Do you think that is correct?

16 MR. TURNER: I have talked to our high
17 school, that is my local high school, every year for
18 the last five years and I talked to one other high
19 school two years ago, and I think in the last five
20 years we have had three people from London attend the
21 College, that is in a city of --

22 MR. WHITE: 162,000.

23 MR. FULLERTON: If there is a decline in
24 the number of students entering College for pharmacy,
25 could you say in the past ten years what the decline
26 has been?

27 MR. TURNER: No, I wouldn't be prepared
28 to give those figures. I don't know whether the decline
29 has been as great as the need. We are losing a lot
30 of pharmacists every year, and there is not the amount



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3 increasing, and the demand for drug service is
4 increasing in many communities. My own son, I couldn't
5 talk him into going into the business.

6 MR. WHITE: What is he going to be, a
7 doctor?

8 MR. TURNER: He is going into commercial
9 art.

2 10 MR. TROTTER: I understand in the last
11 few years the sale of drugs has increased. The actual
12 sale of products. I am referring to the overall
13 picture throughout the country.

14 THE CHAIRMAN: You mean in excess of the
15 progressive increase in population?

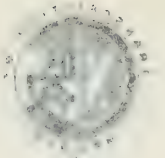
16 MR. TROTTER: Yes. I was wondering if
17 because the drug stores themselves don't seem to be
18 doing so well, could it be that certain firms are
19 concentrating the business in their hands, the drug
20 chain stores?

21 MR. TURNER: To clarify myself on this,
22 when you are speaking of drugs, do you mean drugs and
23 drug sundries, drug store merchandise?

24 MR. TROTTER: I mean prescriptions?

25 MR. TURNER: I think the prescription
26 business in drug stores has increased in the last few
27 years. Our sales, and I think that is general. I think
28 the number of prescriptions filled has been increased.

29 MR. TROTTER: If you read the statement
30 of the drug companies, who manufacture them, their



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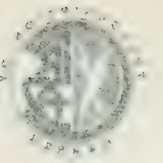


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2 in the last two or three years. The pharmacist does
3 not seem to have shared in the prosperity, and I
4 wondered whether a certain group, or the chains are
5 making more money in proportion to the rest of the
6 pharmacists?
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8 MR. TURNER: No I don't think so. I
9 think our biggest difficulty is that our overhead has
10 increased. The amount of money we have to pay a druggist
11 has increased over the past, as you read in an earlier,
12 I believe an Association brief the wages of pharmacists
13 have tripled in the last ten or twenty years. All our
14 expenses have gone up. Our dispensary expenses, our
15 bottles, labels, printing, prescription pads, everything
16 we use has tripled, our wrapping, rent, taxes have gone
17 up, our profits haven't gone up in comparison.

18 MR. TROTTER: Would you say in the area
19 where you work, do the chain drug stores tend to take
20 business away from you as the years go by?

21 MR. TURNER: No, the only thing I think
22 that we experience in our business today is the impact
23 of cut-rate outlets, not necessarily cut-rate drug
24 stores, but outlets who are handling quite a percentage
25 of lines that we used to consider drug store lines,
26 cosmetics. Our cosmetic business of course, which is
27 a fairly profitable business in a drug store, has all
28 but left us to the door-to-door cosmetic sales person.
29 There is one point that we used to be able to retrieve
30 a fair profit on our front store operation, but that is



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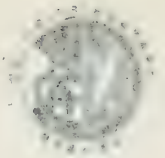
MR. TURNER: No I don't think so. I think our biggest difficulty is that our overhead has increased. The amount of money we have to pay a druggist has increased over the past, as you read in an earlier, I believe an Association brief the wages of pharmacists have tripled in the last ten or twenty years. All our expenses have gone up. Our dispensary expenses, our cost of labor, rent, wrapping, rent, taxes have gone up, our profits haven't gone up in comparison.

MR. TROTTER: Would you say in the areas where you work, do the chain drug stores tend to take business away from you as the years go by?

MR. TURNER: No, the only thing I think that we experience in our business today is the impact of cut-rate outlets, not necessarily cut-rate drug stores, but outlets who are handling quite a percentage of lines that we used to consider drug store lines, cosmetics. Our cosmetic business of course, which is a fairly profitable business in a drug store, has all but left us to the door-to-door cosmetic sales person. There is one point that we used to be able to retrieve a fair profit on our front store operation, but that is



1 leaving, and we are not maintaining the percentage
2 increase in our drug stores that the percentage increase
3 of sales on the drug sundry market is showing.
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2 For instance, if a manufacturer of 'X'
3 brand toothpaste is showing a 20% increase over last
4 year, our sales don't show that, so the increase is
5 going outside our channel.

6 MR. TROTTER: What is the position here?
7 For example, I come back to this point where the drug
8 manufacturers, according to the financial statements,
9 have made tremendous profits in the last ten years,
10 have had a very great increase, and I am wondering if
11 there is some other outlet that the drug manufacturers
12 have or if they are possibly overcharging the druggist.
13 I cannot understand how you fellows are obviously doing
14 so poorly compared to what the drug manufacturers have
15 done, especially in the last ten years.

16 MR. TURNER: I don't know how they base
17 their profits. The schedule I have here shows my
18 operation. The obvious thing, I guess, is that we are
19 not making enough profit on our sales, because in
20 comparison with our overhead we are not.

21 MR. TROTTER: I suppose because the people
22 have to buy the drugs from you you get the blame for
23 the high prices.

24 MR. TURNER: Yes. In the first place, a
25 person doesn't want to be sick, they don't want to go to
26 the doctor. I know that other druggists from London
27 do this. If we know of an authentic case, if a person
28 is an old-age pensioner and they are required to take
29 high-priced medication, we always give them some conside-
30 ration for it. I have three or four people who are



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1 taking cortisone. They couldn't afford to buy it at the
2 best price, which would be the hundred, the original
3 package. They would buy it in ten or twenty-four, which
4 would be high-priced. We charge them the whole bill
5 and let them pay it when they can afford to pay it.
6

7 MR. SUTTON: Doesn't the manufacturer
8 give some consideration there?

9 MR. TURNER: They may start next week.
10 So far they haven't.

11 MR. PRICE: Isn't it the fact that doctors
12 do give some of the patients samples?

13 MR. TURNER: Oh, yes.

14 MR. PRICE: I think they are taken care
15 of in that way, to some extent.

16 MR. TURNER: Yes; and we do, and we have
17 in our operation throughout the years. I have carried
18 people for ten years, their family growing up. We have
19 restricted our credit to a certain extent on everything
20 except essential drugs. Our accounts receivable always
21 run between \$3,000 and \$4,000. But that is pretty well
22 unessentials. That may vary from week to week, but on
23 an average that is what runs to.

24 MR. PRICE: What would your bad debts run
25 to, say, in 1960?

26 MR. TURNER: I would say around \$75 a
27 year. That is about all. Some of them, of course,
28 when they get three or four years old, you don't know
29 whether to call them bad debts or retrievable debts.
30 Our hope is that one day when they can they will.



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MR. FRISB: What would your bad debts run

to, say, in 1960?

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1
2 THE CHAIRMAN: With respect to chronic
3 patients requiring prolonged treatment and expensive
4 drugs, have you had any experience where the patient's
5 doctor secured the co-operation of any drug company
6 and a special delivery, shipment was sent to meet this
7 situation at a substantially or reduced price?

8 MR. TURNER: Yes, I have.

9 THE CHAIRMAN: That type of assistance,
10 is the incidence of it frequent?

11 MR. TURNER: I have knowledge of only one
12 manufacturer, a case of one manufacturer.

13 THE CHAIRMAN: Would it run into much
14 money?

15 MR. TURNER: Yes, a considerable amount.
16 I would say that the company supplied the equivalent
17 of \$300 a year. It was a fairly expensive medication.

18 THE CHAIRMAN: And the person was in
19 reduced circumstances?

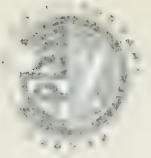
20 MR. TURNER: Yes.

21 THE CHAIRMAN: Was it given as a gift or
22 at a low price?

23 MR. TURNER: It was given as a straight
24 gift. The person was a pensioner in need of a fairly
25 high dosage of this medication, and it was given, sent
26 free of charge. That was on the advice of the physician,
27 with extenuating circumstances.

28 MR. TROTTER: Would the drug companies
29 have many salesmen calling on you?

30 MR. TURNER: Yes.



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MR. TROTTER: Would they call very often?

MR. TURNER: You are talking about prescription drugs?

MR. TROTTER: Yes, the drugs that the manufacturer manufactures.

MR. TURNER: I would say an average of once every two weeks.

MR. TROTTER: Just one man?

MR. TURNER: Yes, one man.

MR. TROTTER: Do you get much in the mails in the way of literature on new drugs?

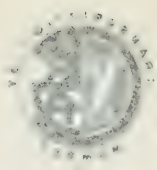
MR. TURNER: We get description brochures, unless the filing card has the information, with the different dosage forms, how it is made up, the dosage and the indications. This is information which is sent to the doctors, too, I believe. We file that, we have that information available. But whenever a new drug comes out that comes along with it. We are on an automatic shipment of new products with supply houses. When they bring out a new product we automatically get stock, along with the filing card information.

MR. WHITE: Mr. Donaldson suggested that druggists charge a dispensing fee only and not mark up the actual drugs themselves.

MR. TURNER: I definitely think there is a lot of merit in it, providing the fee is sufficient.

MR. WHITE: Do you know of any discussion on that subject in the Association?

MR. TURNER: No, I don't think that has



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2 ever been discussed.

3 MR. WHITE: Is your experience the same
4 as Mr. Donaldson's in the deterioration of drugs?

5 MR. TURNER: In some cases, yes; and I
6 would qualify that in saying that most of, not all,
7 but a lot of the major pharmaceutical companies in my
8 experience - now, whether it is the company policy or
9 whether it is representative policy - we have had fairly
10 good luck in returning full packages, but broken packages
11 is mostly at the discretion of the local representative;
12 if he can help you out in any way he will. But it is
13 not the policy to take back broken packages.

14 MR. WHITE: How often would you have been
15 visited by the Inspector from the College of Pharmacy
16 in the last ten years?

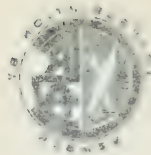
17 MR. TURNER: I think seven or eight times.

18 MR. WHITE: Would he have occasion to
19 discuss prices with you on those visits?

20 MR. TURNER: No, he has never discussed
21 the prices.

22 MR. WHITE: You mentioned that your
23 profit was 6.4% on a volume of \$129,000, and then later
24 you mentioned a gross income of what I understood to be
25 profit of \$6,995, and I calculate that to be \$8,256,
26 and I am wondering if the difference is the profit left
27 in the business.

28 MR. TURNER: No. I may have created a
29 misunderstanding there. My average gross profit over
30 the past ten years was around 7%. Last year it wasn't



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1 7%. As I remember it - now, I haven't that sheet here -
2 it was 6 point something.

3 MR. WHITE: But the salary figures you
4 mentioned, would they include the money left in the
5 business for additional stock and suchlike?

6 MR. TURNER: Yes.

7 MR. WHITE: It wasn't your drawings only?

8 MR. TURNER: No.

9 THE CHAIRMAN: The figures you used were
10 6.8, reducing to 6.4 last year.

11 MR. TURNER: I believe you are right there.
12 I believe the 7% was the figure I used in determining
13 what a clerk should produce to give a 7% return.

14 MR. WHITE: The dispensing fee in London
15 is 50 cents.

16 MR. TURNER: Yes.

17 MR. WHITE: But the College recommend
18 75 cents.

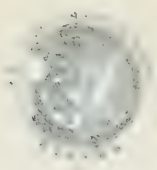
19 MR. TURNER: Yes.

20 MR. WHITE: You said your gross profits
21 on prescription drugs was 50%. Was that an assumption
22 or was that an exact gross profit?

23 MR. TURNER: On the schedule we are using
24 in our store at the present time, including our fee and
25 the extra cost plus the breakdown, it works out to 50%
26 in medication.

27 MR. WHITE: Are you a member of the Drug
28 Trading Company?

29 MR. TURNER: No.



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2 MR. WHITE: You say the salesman visits
3 you once every two weeks.

4 MR. TURNER: I am speaking of representa-
5 tives from each company. The representative from one
6 company would visit us on an average of once every ten
7 days to two weeks.

8 MR. WHITE: How many companies would call?

9 MR. TURNER: Well, I would have to stop
10 and figure that up. I guess it would probably be
11 fourteen or fifteen.

12 MR. WHITE: So every day you see one or
13 two men.

14 MR. TURNER: Oh, yes. As far as the
15 pharmaceutical men are concerned, one of the reasons
16 they come into the store, at least our experience, they
17 usually come in and check their stock and bring our
18 stock, order our stock for us, check over any outdated
19 stuff, leave any literature they have to, and they are
20 on their way. We don't spend much time with them unless
21 there is a new product which has to be specifically
22 explained. But they are in and out on their own.

23 MR. WHITE: That ~~concludes my~~ questions.
24 But since I am a customer of Mr. Turner's, may I take
25 it upon myself to thank Mr. Turner for coming down here
26 and appearing before the Committee? We very much
27 appreciate it.

28 THE CHAIRMAN: We will now adjourn until
29 2.15 tomorrow afternoon, when we will meet in Committee
30 Room No. 4 on the third floor.



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Select Committee on Drugs

HEARINGS

HELD AT

PARLIAMENT BUILDINGS

TORONTO, ONTARIO

VOLUME No.: ~~18~~ DATE:

18

JUNE 8 1961

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Thursday,
the 8th of June, 1961,
at 2.30 p.m.

COMMITTEE:

MR. H.L. ROWNTREE, Q.C. -- Chairman

MR. A. WREN

MR. J.A. FULLERTON

MR. J. TROTTER

MR. R.E. SUTTON

MR. R.J. BOYER

MR. N. WHITNEY

MR. H.J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G.F. LAVERGNE

MR. S.J. GADSBY, F.C.I.S., Secretary

MR. HAROLD A. RICE -- Committee Counsel

MR. W.J. AYERS -- Accounting
Consultant to the
Committee



1
2 --- On resuming at 2.30 p.m.

3
4 THE CHAIRMAN: I am calling this meeting
5 together. Firstly, we have a meeting tomorrow morning
6 and we have finally got to Committee Room 2. Why is it,
7 Mr. Secretary, that we cannot use Committee Room 2
8 regularly when the ventilation is so poor up here?

9 THE SECRETARY: The Lieutenant-Governor
10 requires it, sir, for the receptions, for the cloakrooms.

11 THE CHAIRMAN: Have you discussed it with
12 him?

13 THE SECRETARY: Yes sir, he is going to
14 do better next time.

15 THE CHAIRMAN: This happens to be one of
16 the most difficult weeks in the year for me and I have
17 a commitment which I cannot avoid for tomorrow morning.
18 Accordingly I will not be here. That matters little to
19 this Committee because the rest of the members are
20 quite competent to carry on. I went over the list of
21 those who will be here tomorrow, and you will understand
22 that it is difficult and, in fact, undesirable to
23 request someone who has made arrangements to be here to
24 change his appointment, particularly when he comes from
25 another jurisdiction. Accordingly I will move and I
26 hope someone will second that Mr. Norris Whitney will
27 be Vice-Chairman and in my absence carry on in the
28 morning.

29 MR. WREN: I second that.

30 THE CHAIRMAN: Mr. Wren seconds it. Those

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hope someone will second that Mr. Norman Whitney will

be Vice-Chairman and in my absence carry on in the

Chairman.

MR. WHEAT: I second that.

THE CHAIRMAN: Mr. Wheat seconds it. Those



1
2 in favour? Contrary, if any? The amendment will be
3 carried.

4 Now, I would like to address a few words
5 before we start to the group who are appearing before
6 us. I have had numerous and many conversations with
7 individual druggists and those connected with the opera-
8 tion of retail pharmacies. I don't think I need expand
9 or elaborate on the fact that this Committee is here to
10 hear the evidence, to receive the representations and
11 ultimately to bring in its report. I know most of the
12 members of this Committee personally, in fact all of
13 them, and I think I can assure you they are approaching
14 this problem in an unprejudiced way. I was very much
15 impressed with the evidence which was presented yester-
16 day and the briefs. You do not have to be a professional
17 witness to appear before a Select Committee of this
18 Government. This morning I received several 'phone
19 calls which indicated to me that the membership and the
20 practising pharmacists of your organization, the Ontario
21 Retail Association, didn't know even that the meetings
22 were being held this afternoon or yesterday. I would
23 like to ask this question - is Mr. Robertson here? Mr.
24 Estey?

25 MR. ESTEY: Yes sir.

26 THE CHAIRMAN: I would like to ask you
27 what steps were taken to notify your membership these
28 hearings were under way?

29 MR. ESTEY: If I may, Mr. Chairman, I
30 would like to make that enquiry.



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were being held this afternoon on Wednesday. I would

like to ask this question - Is Mr. Henderson here? Mr.

Bates?

THE CHAIRMAN: I would like to ask you

hearings were under way?

MR. BATES: If I may, Mr. Chairman, I



1 Mr. Chairman, I am advised no notice of
2 this specific date for hearing was circulated to the
3 membership of the Association, however in preparation
4 of the brief and draft preliminary briefs memoranda was
5 circulated to the full membership of the Association.
6 They all knew of the existence of the Committee and
7 they all knew of the substance of the presentation made.
8 They did not know the date it was going to be held.
9 Does that answer your question?
10

11 THE CHAIRMAN: And the date, however, was
12 arranged by appointment with the Secretary of the
13 Committee?
14

15 MR. ESTEY: Yes sir.
16

17 THE CHAIRMAN: The reason I raised this,
18 I had a letter last week from a man in an Ontario town
19 who raised some comments which obviously told me he knew
20 nothing about the efforts which your Association was
21 making to present the facts of the story of the retail
22 pharmacists in Ontario.
23

24 MR. ESTEY: I would be curious to know
25 whether the man responded to the circular which we sent
26 out. In all associations, Mr. Chairman, as you and the
27 members of the Committee will be well aware and will
28 appreciate, it is very difficult to get 100% or even
29 50% to take an active part in anything even for their
30 own good. It is certainly possible that some member
pharmacists didn't know what is being presented because
we cannot make them read their mail and make them reply.
The briefs indicated we received 400 responses and of

Mr. Chairman, I am advised no notice of

this specific date for hearing was circulated to the membership of the Association, however in preparation of the brief and draft preliminary debate memoranda was circulated to the full membership of the Association.

They all knew of the existence of the Committee and they all knew of the substance of the presentation made. They did not know the date it was going to be held.

Does that answer your question?

THE CHAIRMAN: And now, however, was

arranged by appointment with the Secretary of the

MR. ESTHER: Yes sir.

THE CHAIRMAN: The reason I raised this,

I had a letter last week from a man in an Ontario town who raised some comments which obviously told me he knew nothing about the efforts which your Association was making to present the facts of the story of the retail pharmacists in Ontario.

MR. ESTHER: I would be anxious to know

whether the man responded to the circular which we sent out. In all associations, Mr. Chairman, as you and the members of the Committee will be well aware and will appreciate, it is very difficult to get 100% or even 50% to take an active part in anything even for their own good. It is certainly possible that some member pharmacist didn't know what is being presented because we cannot make them read their mail and make them reply. The briefs indicated we received 400 responses and of



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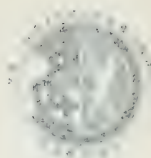
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4 THE CHAIRMAN: This isn't a matter of
5 criticism, Mr. Estey, it is just a matter of recording
6 a fact.

7 MR. ESTEY: Yes sir.

8 THE CHAIRMAN: On receipt of that letter
9 I had my secretary, Mrs. Fraser, telephone this gentle-
10 man on long distance to tell him that the O.R.D.A. was
11 appearing with representative druggists to present their
12 case and suggesting, it being a public hearing, that
13 you might want to be present. Of course, the answer was
14 he had left on a three-week vacation after writing the
15 letter.

16 I just want to record the situation because
17 this is a public hearing and the place to present views
18 of anyone, whether members of the Association or indivi-
19 duals who have their own personal views is right at
20 this Committee, right here. That applies and this
21 Committee will sit for two years if we have to, to give
22 everyone the right to appear. I don't think it advances
23 the cause of any particular argument for someone to
24 write and advance their case without making it subject
25 to cross-examination and so on. No one need fear
26 coming before this Committee, Mr. Estey, I am sure you
27 understand that.

28 MR. ESTEY: Yes, I appreciate that, sir.
29 I think I should say on this occasion the members of
30 the Committee of this Association who have been



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2 delegated the responsibility of appearing here have had
3 a rather refreshing surprise to find the case as the
4 Chairman has just described. We have other druggists
5 who today will present their view of the retail drug
6 business in their particular community.

7 THE CHAIRMAN: Mr. Rice.

8 MR. RICE: I think Mr. Estey wants to
9 introduce the witness.

10 MR. ESTEY: Mr. Chairman, the line of
11 presentation was Mr. Wilkinson read the brief for the
12 Association and then two druggists made presentations
13 by describing the nature of their business in their
14 particular community. We started with Renfrew, a rather
15 small population, and then in London, Ontario, and we
16 have today Mr. Isaacson, of the Lawrence Park Plaza in
17 Toronto, and also Mr. Keating of Guelph. If it meets
18 with the wishes of the Committee we would like to intro-
19 duce Mr. Isaacson, have him tell his own story, and
20 then Mr. Keating, and then you may after they have been
21 examined wish to put some questions to Mr. Wilkinson
22 who read the main Association brief to you. If that
23 procedure is acceptable I will introduce Mr. Isaacson
24 of Lawrence Park Pharmacy in Toronto.

25 THE CHAIRMAN: Before we start, Mr.
26 Isaacson, I directed yesterday a question towards the
27 Ontario Retail Association as to the particular grouping
28 which it represents. Of course the Ontario Retail
29 Druggists' Association is the largest in Ontario, and
30 probably the Toronto Retail Druggists' Association would

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come next. There must be, and I assume there are other
associations in other cities. I don't want to direct
this question to you. It may be someone else, perhaps
Mr. Estey could answer it, but as I understand it this
brief from the Ontario Retail Association represents
all the constituent associations, and secondly does it
represent the ROKEAH? The ROKEAH, is what I understand
is a professional pharmaceutical fraternity of Jewish
pharmacists?

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MR. ISAACSON: Yes, Mr. Chairman, I
happened to be one of the founders of the ROKEAH
Pharmaceutical Association back in 1936. It was formed
specifically at that time for the purpose of organizing
the Jewish druggists who had no particular part in the
overall picture in Toronto, not known to the other pharma-
cists. We felt that we should be known to each other as
pharmacists, and the intention, of course, was to pro-
mote the same principles and ideals of pharmacy and to
work together with the Toronto retail pharmacists as a
whole. Every member of the ROKEAH is a member of the
Toronto Retail Pharmacists' Association.

23
24
THE CHAIRMAN: What membership do you
have in the ROKEAH?

25
MR. ISAACSON: About 400.

26
27
THE CHAIRMAN: And in the Toronto Retail
Association?

28
29
30
MR. ISAACSON: About, oh, 700, 650. They
may not all be paid-up members. That is the membership,
that is the number of pharmacists. Most of them are



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B/MR/hm

1 members of the Toronto Retail Pharmacists' Association.

2 THE CHAIRMAN: Mr. Estey can we assume
3 then that this brief from your Association does cover
4 these other various organizations in Ontario?

5 MR. ESTEY: Yes Mr. Chairman. This
6 Association is governed by council which draws its
7 membership from two main sources. The first source
8 are member organizations which are regional pharmacy
9 association, ROKEAH and the other source is a
10 geographic representation of constituencies as well
11 as representative sources from which they draw sixteen region
12 members so this brief is representative, so far as
13 any brief can be for a voluntary association, is
14 representative of the opinions and submissions not only
15 of individual members but the component organization
16 members and the brief has been approved by the council
17 and by the governing body.

18 THE CHAIRMAN: Just one last question
19 on the identification of these groups. They are
20 commercial association groups in the same sense as
21 rubber, tire associations or something like that? Do
22 any of them involve a commercial aspect or a commercial
23 tie?

24 MR. ESTEY: Other than the immediate
25 operation of a retail pharmacy?

26 THE CHAIRMAN: Yes?

27 MR. ESTEY: No.

28 THE CHAIRMAN: Is ROKEAH confined to
29 Toronto Mr. Isaacson?

30 MR. ISAACSON: Yes. Mr. Chairman and



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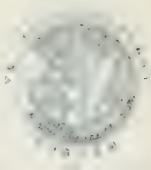


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2 Isaacson. I was born in Belfast, Northern Ireland
3 in 1899. Our family immigrated here in 1913. I have
4 lived in Toronto since that time.
5

6 In 1919 I apprenticed in pharmacy with
7 Mr. W. G. Becker for four years. I graduated from
8 the Ontario College of Pharmacy in 1924 and received
9 my degree of Phm.B. from the University of Toronto
10 that same year.

11 I have owned and operated drug stores in
12 Toronto for the past 37 years. In every hamlet, village,
13 town and city in the Province of Ontario one will find
14 what is commonly known as the corner drug store;
15 whether they are on the corner or the middle of the
16 block, they are manned by a special breed of men and
17 women who have dedicated themselves to serve the people
18 in their community. They spend long hours at this
19 task. They do many chores and menial jobs but they are
20 first and foremost on duty in their professional
21 capacity as pharmacists to supply the people promptly
22 and effeciently with drugs and medicines and general
23 health needs.

24 Our motto is "We treat the sick well" and
25 we mean every word of it. We pharmacists make no
26 great fortunes from the practising of our profession.
27 We make a fair living. We derive our deepest pleasure
28 from getting to know everyone on the block, the grocer,
29 the butcher, the baker, the barber, and the hardware man
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2 and particularly all the families who live in the
3 neighbourhood. There is probably not a single family
4 in Ontario whose members have not at one time or
5 another dropped into a drug store to purchase some of
6 their every day needs; to get a prescription filled
7 or just pass the time of day.

8 The druggists are a hard working, law
9 abiding group of citizens who are deeply integrated
10 into the life of their community. Drug stores have
11 their own peculiar atmosphere different from any other
12 type of store and we believe the people like it just
13 the way it is.

14 In a survey recently people were asked
15 what appealed to them most in drug stores and the
16 answers invariably were firstly: The friendliness
17 of the staff. Secondly: Their confidence in the
18 integrity of the pharmacists. Thirdly: The fact that
19 he carries a large variety of good quality merchandise
20 and fourthly: The modern, well-lighted, neat and clean
21 appearance of the store. The question of price, though
22 it had its place in this survey, was not a primary
23 consideration.

24 Naturally, to the sick the cost of medicine
25 is a great factor but the primary function of the
26 medication is to help the patient get well as quickly
27 as possible. No druggist is happy when his customers
28 are sick because he knows they spend more in his store
29 when they are well. Apart from the monetary or
30 commercial aspect the pharmacist is always happy when



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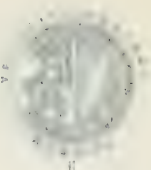
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1 the patient recovers from his illness and is pleased
2 that he had some part in hastening this recovery,
3 through the practise of his profession. Hence, the
4 significance of the motto above mentioned "We treat
5 the sick well".

6
7 The pharmacist, according to provincial
8 and federal laws must be on duty in the interest of
9 public health to dispense drugs and medicines. The
10 function of the pharmacist is to dispense prescriptions
11 secundum artem according to the art of the apothecary.
12 It's a cardinal rule to fill a prescription not only
13 as ordered by the doctor but with the outmost care and
14 accuracy.

15 Professional ethics require us to use
16 the best quality ingredients to assure the patient
17 getting the best result from the medication. He must
18 concentrate exclusively in the dispensing of the
19 prescription to avoid any errors and only after the
20 various operations in filling it have been carried out
21 and the prescription completed will he apply himself
22 to pricing. Pharmacists are entitled to a salary
23 commensurate with their professional training, skill
24 and knowledge in the handling, storing and dispensing
25 of potent drugs. Many drugs must be kept refrigerated.
26 There can never be a self-serve dispensary. Considerable
27 investment is incurred because of the need to keep a
28 well stocked dispensary and other lines of merchandise,
29 as well as fixtures and equipment in order to have what
30 the customer wants when he wants it to be ready in



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1 emergency in sickness and in health and to give the
2 public that special type of service which it has
3 enjoyed through the years.
4

5 Someone said the most expensive drug is
6 the one that is not available at the moment when it
7 is most thoroughly needed because it could cost a life.

8 Since the latter half of 1960 the prices
9 of drugs particularly in the high price range have
10 dropped substantially. This is due to reduction by
11 the pharmaceutical suppliers both of brand name products
12 and of those firms who sell their products under generic
13 labels. This has been the pattern generally followed
14 by pharmaceutical suppliers over the years. Any
15 reduction in price to the pharmacist is automatically
16 passed on to the consumer. I would like to repeat that
17 Mr. Chairman that any reduction in price to the
18 pharmacist is automatically passed on to the consumer.
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From a survey which I have made from returns by 446 drugstores which sent in to the Ontario Retail Pharmacists' Association in April of this year the average price of prescriptions was \$3.30. In the fall of 1960 it was \$3.76. We welcome reductions in the prices, since we have had to bear the brunt of most of the complaints about the prices of drugs, even though we have no control or say as to prices charged by the suppliers. This \$3.30 prescription average was computed from the weekly prescription income and the number of prescriptions of these aforementioned stores, representing 60,000 prescriptions weekly.

To show that druggists do not make excessive profits in their stores, I have prepared these schedules attached hereto. These have been compiled by myself from the information supplied by the aforementioned drugstores, and it also includes the figures from our own store.

These figures show, it is on page 4, average annual sales of \$105,500.00 per store, see Schedule A. A gross profit on this volume of 32% on sales. A prescription income of \$22,000.00, which is 20.9% of total sales. A total overhead of 28%, including proprietor's salary, leaving a net profit of 4% before income taxes, amounting to \$4,220.00.

It is significant to point out of these 446 drugstores, over 50% had sales averaging only \$66,000.00 yearly.

While these stores also show a gross



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1
2 profit of 32% of sales, their prescription income is
3 only 15% of total sales, amounting to \$9,884.00. The
4 net profit in these prescription departments amounted
5 to \$2,204.00 for the year.

6 Most of these latter stores are one-man
7 stores, employing part-time pharmacists. They will be
8 found mostly in small communities scattered throughout
9 the Province.

10 All of which is respectfully submitted to
11 this Select Committee for their consideration.

12 Would you like me, Mr. Chairman, to go
13 over these schedules at all?

14 THE CHAIRMAN: I think you might leaf
15 them over and make such comments as you think fit.

16 MR. ISAACSON: The only comments I could
17 make is perhaps what I have also filed some of the, a
18 partial list of price reductions. I just noted here
19 for the information of the Committee just a partial
20 list we took at random of price reductions by pharma-
21 ceutical suppliers on drugs like tetracycline capsules.
22 For achromycin the 1960 price of \$9.44 for 16 is reduced
23 in 1961 to \$7.90, a \$9 item reduced to \$7. Meproamate,
24 which is a very popular tranquilizer, was \$6.00 for 50
25 in 1960 and is now \$5.00 for 50. Penicillin was \$3.30
26 in 1960, it is now \$2.00. P.G. Atric was \$3.25 in
27 1960, and is now \$2.25. PenVee, which is a penicillin
28 compound, 250 milligramme tablets was \$7.50 for 12 in
29 1960 and is now \$4.50 for 12.

30 THE CHAIRMAN: When did those prices start



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THE CHAIRMAN: When did those prices start

start?



1
2 to be reduced?

3 MR. ISAACSON: I would say they started
4 in the latter half of 1960.

5 THE CHAIRMAN: Any relationship to the
6 existence of this Committee?

7 MR. ISAACSON: It could be. I am not
8 prepared to say. We don't know what their thinking
9 has been, but it could well have influenced the hastening
10 of reduction in prices.

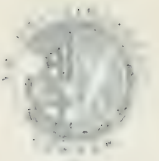
11 MR. WREN: But you think it was long over-
12 due?

13 MR. ISAACSON: I think so. We welcome
14 reduction in prices at all times. We would be happy if
15 we didn't have a single bottle in our dispensary that
16 cost more than \$5.00.

17 THE CHAIRMAN: Do you think that day will
18 ever come?

19 MR. ISAACSON: Well, all the present
20 preparations will come down to lower than \$5.00, but
21 there will be newer ones as they discover new drugs,
22 which will again have to be charged at whatever price
23 they say. We have no control over that.

24 THE CHAIRMAN: Without involving you in
25 any discourse on economics or the theory of pricing,
26 whether it be a metal product which has required some
27 many hundreds of thousands of dollars in research, or
28 whether it be a synthetic textile, so-called synthetic,
29 or man-made product, which costs millions of dollars
30 to research and millions of dollars to establish the



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MR. ISAACSON: I think so. We welcome

reduction in prices at all times. We would be happy if

we didn't have a single bottle in our dispensary that

cost more than \$5.00.

THE CHAIRMAN: Do you think that day will

ever come?

MR. ISAACSON: Well, all the present

preparations will come down to lower than \$5.00, but

there will be newer ones as they discover new drugs,

which will again have to be charged at whatever price

they say. We have no control over that.

THE CHAIRMAN: Without involving you in

any discourse on economics or the theory of pricing,

whether it be a metal product which has required some

many hundreds of thousands of dollars in research, or

whether it be a synthetic textile, so-called synthetic,

or man-made product, which costs millions of dollars

to research and millions of dollars to establish the



1
2 plant before anything was produced. This is a long
3 question sir.

4 The first products that come off those
5 plants would never repay the total, or have any relation-
6 ship, might never have any relationship to a product
7 or unit factor in relation to the cost of the plant.

8 Are you with me on what you are talking
9 about? And it might very well not make any difference
10 whether it was \$10.00 a unit or \$110.00 a unit. The
11 instigator or manufacturer would be absorbing it in
12 the first instance.

13 Do you understand what I am talking about?
14 He has to start to produce his product at a price
15 which will not compensate him for his investment.

16 MR. ISAACSON: He would be taking a loss
17 then.

18 THE CHAIRMAN: At the outset, until he
19 establishes the market.

20 MR. ISAACSON: I think volume would probably
21 be the greatest factor.

22 THE CHAIRMAN: Let us take the case in any
23 of these situations where the plant has just opened. It
24 is a \$20,000,000.00 plant. There has been \$10,000,000.00
25 on research, and the first product rolls off, and that
26 is not going to sell for \$10,000,000.00, is it?

27 MR. ISAACSON: No.
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is not going to sell for \$10,000,000.00, is it?

MR. ISAACSON: No.



THE CHAIRMAN: Now, would it follow that the price may or may not have any relationship to the investment involved, whether it be five or 105 dollars?

MR. ISAACSON: Well, again I have no idea at all of how manufacturers arrive at the price to charge to the pharmacist or to the wholesaler.

THE CHAIRMAN: Do you ever complain to anyone about the high price of goods?

MR. ISAACSON: Constantly. Only to the salesmen. They are the only people we have a chance to speak to.

THE CHAIRMAN: What did you say to him?

MR. ISAACSON: Well, usually it comes when a salesman introduces a new product and he tells us the advantages of the new product they have put on the market and they tell us they will be introducing this to the medical profession and that we will be advised, well-advised, to have the stock so that when a prescription comes in we will be ready to fill it and not have to run around looking for a product; and many of us accept what is called automatic shipments, that is rather than lose an opportunity for filling a prescription for a new product we allow the company to send us a bottle, or whatever it is, if it is one size or two sizes, so we will have it in our dispensary.

THE CHAIRMAN: Is that free?

MR. ISAACSON: No, pay the regular price for it.

THE CHAIRMAN: When you talk of losing



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1
2 the opportunity of filling a prescription you raise an
3 entire area of discussion. It is physically impossible
4 to stock all the items you are called upon to supply.
5 Do you have any exchange arrangements?

6 MR. ISAACSON: Yes. Our store is up on
7 north Yonge Street, and there are probably ten stores
8 north of us and ten stores south of us who are constantly
9 calling us for help, and we are glad to give it, under
10 exchange, and if we happen to have it ahead of the other
11 drugstores we will give it to them as a courtesy to them.

12 THE CHAIRMAN: You loan it to them.

13 MR. ISAACSON: Either that or we would
14 reorder it the next day.

15 THE CHAIRMAN: Is that an advantage to the
16 chain store operations?

17 MR. ISAACSON: No.

18 THE CHAIRMAN: How many stores are you
19 interested in?

20 MR. ISAACSON: About 18, 19.

21 THE CHAIRMAN: As a matter of fact, my
22 information is that you are regarded as a highly repu-
23 table druggist in Metropolitan Toronto.

24 MR. ISAACSON: Thank you very much.

25 THE CHAIRMAN: Wouldn't you use the
26 existence of these various stores, whether they be owned
27 or affiliated and you could cut down your inventory?

28 MR. ISAACSON: Most of these stores - if
29 you are thinking of the plaza-type store, scattered all
30 over the metropolitan area --



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2 THE CHAIRMAN: When you say the "plaza-
3 type", I understood you had the word "plaza" copyrighted.

4 MR. ISAACSON: We were the first ones to
5 call it Plaza Drugstores Limited; but there are many
6 other stores of a similar nature in shopping centres or
7 plazas.

8 THE CHAIRMAN: Do you purchase together?

9 MR. ISAACSON: Yes.

10 THE CHAIRMAN: Common purchasing programme.

11 MR. ISAACSON: Certain items. But a large
12 percentage of purchases for each drugstore which is
13 still operating as a single unit in this particular area
14 are from Drug Trading Company or National Drug.

15 THE CHAIRMAN: I don't want to interfere
16 with Mr. Rice's proceedings, but before we let him
17 proceed, as a result of a 'phone call this morning that
18 I had I would like to ask you a question.

19 Have you ever been approached by the
20 manufacturer or distributor of so-called prescription
21 drugs to purchase from his organization at a cheaper
22 price and substitute them for other goods described on
23 the doctor's prescription?

24 MR. ISAACSON: We would never substitute
25 any drugs.

26 THE CHAIRMAN: That is not the question.
27 Have you ever been asked to?

28 MR. ISAACSON: No. Certainly not in my
29 case.

30 THE CHAIRMAN: Have you ever heard of



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THE CHAIRMAN: Have you ever heard of



1 anyone doing any business that way?

2 MR. ISAACSON: No.

3 THE CHAIRMAN: To put the question fairly,
4 my information this morning is that a certain group of
5 drugstores were approached by one manufacturer who
6 sold under a bulk prescription and who had imported the
7 goods from Japan and/or Italy at a much cheaper price
8 and sold them to the retailer at a cheaper price and
9 suggested he substitute them on his own volition against
10 the doctor's prescription.

11 MR. ISAACSON: I certainly would be no
12 party to that.

13 THE CHAIRMAN: Did you ever hear of it?

14 MR. ISAACSON: No.

15 THE CHAIRMAN: Mr. Rice.

16 MR. RICE: You are tabling your survey
17 to the Committee.

18 MR. ISAACSON: Yes, the different pres-
19 criptions and what we lose on some prescriptions and
20 what we make on others. There is a point, and up to
21 that point we lose money in dispensing them.

22 MR. RICE: What is that point?

23 MR. ISAACSON: I would say at a \$1.60.
24 Anything priced less than that, there is no profit. At
25 a \$1.60 the net profit is nil, and it starts going up
26 bit by bit from then on.

27 MR. RICE: This survey that you have
28 attached here, that includes your own operation, and
29 you have told the Chairman that you are interested in
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2 18 or 19 stores. Does it appear as 18 or 19 different
3 stores in the survey or are they as one unit?

4 MR. ISAACSON: Both actually. They would
5 be in the total 446-odd stores. It has always been my
6 habit to do a lot of figuring in the operation, to know
7 exactly where we stand at all times, to know how much
8 dispensing business we do in relation to the total
9 volume and so forth, and it is pretty constant.

10 MR. RICE: On this partial list of drugs,
11 starting in the fall of 1960, are any of those drugs
12 manufactured by several manufacturers? In other words,
13 is there competition in some of these drugs?

14 MR. ISAACSON: They were different firms -
15 Letterley's, Kayser, Bristol, British Drug Houses.

16 MR. RICE: Would there be other manufac-
17 turers manufacturing these drugs you have listed here
18 who have not lowered their prices?

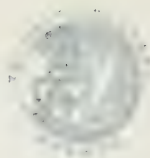
19 MR. ISAACSON: Yes.

20 MR. RICE: Do you know of any drug
21 produced by one manufacturer only who has reduced his
22 price, a drug that is manufactured or supplied by one
23 manufacturer only?

24 MR. ISAACSON: Chloromycetin. Butazolidin
25 has not come down.

26 A MEMBER OF THE AUDIENCE: Yes, it came
27 down a dollar. It came down a year ago.

28 THE CHAIRMAN: I think to keep the record
29 straight we'd better make sure that it reads that Mr.
30 Isaacson gave an answer but there were other



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Isaacson gave an answer but there were other



1 observations from the audience.

2 MR. RICE: Do you yourself operate the
3 store at Lawrence Park?

4 MR. ISAACSON: Yes, in conjunction with
5 my son who is a pharmacist and another pharmacist who
6 is a partner in the business.

7 MR. RICE: How long have you operated
8 the store, that particular store?

9 MR. ISAACSON: 26 years.

10 MR. RICE: Can we take that store as a
11 representative sample of your other stores?

12 MR. ISAACSON: Yes, I would call it a
13 good store.

14 MR. RICE: What would be the cost, total
15 cost of equipment and stock you would have invested in
16 that store?

17 MR. ISAACSON: Inventory in the first of
18 the year was around \$30,000.00 and fixtures and equipment
19 would be around \$17,000.00, \$18,000.00.

20 MR. RICE: How many different drugs would
21 that stock include?

22 MR. ISAACSON: Pardon?

23 MR. RICE: Can you give us any approximate
24 idea as to the number of drugs you have in stock at
25 that particular store?

26 MR. ISAACSON: To make my answer clear,
27 was that question in reference to the total inventory
28 in the whole store or just the prescription part?

29 MR. RICE: We will confine it just to
30 prescriptions.



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2 MR. ISAACSON: We don't have \$30,000.00
3 in the dispensary.

4 MR. RICE: What would be invested in the
5 dispensary?

6 MR. ISAACSON: Between \$8,000.00 and
7 \$9,000.00.

8 MR. RICE: That is in stock and equipment?

9 MR. ISAACSON: Just stock.

10 MR. RICE: How many drugs?

11 MR. ISAACSON: It would ...

12 THE CHAIRMAN: Drugs -- you mean items?

13 MR. RICE: Items.

14 MR. ISAACSON: Different items, we carry
15 over 5,000.

16 MR. RICE: What personnel would you have at
17 that particular store in connection with the prescription
18 department?

19 MR. ISAACSON: I won't count myself because
20 I don't -- I am not doing prescriptions now. I am more
21 or less just acting in an advisory capacity. My son
22 and the other pharmacist do the dispensing.

23 MR. RICE: Could you tell us what the
24 gross sales were from that particular store?

25 MR. ISAACSON: The total sales or dis-
26 pensary sales?

27 MR. RICE: The gross sales from the
28 particular store for the prescription department.

29 MR. ISAACSON: The prescription department
30 would be around \$35,000.00.

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1
2 MR. RICE: How many prescriptions would
3 that be, approximately?

4 MR. ISAACSON: About 11,000.

5 MR. RICE: Where do you obtain your drugs,
6 from wholesale manufacturers?

7 MR. ISAACSON: Everybody. We buy a lot
8 from Drug Trading or National Drug. Lily products
9 are sold at National Drug so we have to get them there,
10 and we buy a lot direct from the different pharmaceutical
11 houses.

12 MR. RICE: Is there any ordinary discount
13 that you purchase your drugs at?

14 MR. ISAACSON: The usual is 40% off the
15 list, off invoice.

16 MR. RICE: Is that where you buy from
17 the manufacturer or from the wholesaler?

18 MR. ISAACSON: Well, we get it from the
19 wholesaler -- it is higher on the invoice, but Drug
20 Trading Company, for example, anything we buy from
21 Drug Trading Company, it is co-operative, and we enjoy
22 a rebate or commission, is probably the proper word,
23 at the end of six months. Every six months we get back
24 a rebate which could be ten per cent. It wasn't ten
25 per cent last year. They had to drop it. We didn't
26 get ten per cent, but as a rule that is included in
27 the cost of the drug.

28 THE CHAIRMAN: Following that through,
29 does that item of rebate go into your revenue in your
30 financial statement and is that reflected, included in

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1 the net profit to which you referred?

2 MR. ISAACSON: Oh yes, it is included
3 because it is a credit against purchases. In other
4 words we just keep on buying more merchandise against
5 that credit until it is used up.

6 THE CHAIRMAN: I am just testing the
7 statistics which are being advanced to us. Is that
8 a fringe benefit which is not shown here or is it included
9 in your gross revenue?

10 MR. ISAACSON: Well, that is certainly a
11 great benefit to have it. National Drug give ten per
12 cent.

13 THE CHAIRMAN: Where is it included? Is
14 it reflected in the figures given to us yesterday and
15 today?

16 MR. ISAACSON: I would say so. It is
17 not paid out as far as I know. It is not paid out by
18 cheque or in any way. We don't keep the credit from
19 Drug Trading Company, it is just credited -- it is
20 credited against purchases.

21 MR. WREN: Is that passed onto the
22 customer?

23 MR. ISAACSON: Well, it is part of the
24 cost of the merchandise.

25 THE CHAIRMAN: If it is included in the
26 revenue of the company then it becomes part of their
27 revenue which would relate to their net profits before
28 taxes.

29 MR. WHITE: This rebate from the wholesaler
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MR. WHITE: This rebate from the wholesale



1 would be reflected in the cost of goods sold.

2 MR. ISAACSON: If it weren't for that
3 our gross profit wouldn't be 32%.

4 MR. WREN: You don't show it in your
5 financial statement as discounts taken?

6 MR. ISAACSON: It reflects in the net
7 purchases.

8 MR. WREN: I understand that. I say does
9 it show in your cost of sales or does it show as a
10 separate revenue item as discount taken?

11 MR. ISAACSON: It isn't put on the
12 financial statement by the auditors as a credit.

13 THE CHAIRMAN: It is shown as a source
14 of revenue?

15 MR. ISAACSON: It is just we get so much
16 merchandise from....

17 THE CHAIRMAN: You take it in cash or
18 merchandise?

19 MR. ISAACSON: In merchandise.

20 MR. WHITNEY: This would actually show
21 as a deduction, deducted from the total purchases in
22 the year?

23 MR. ISAACSON: It doesn't show -- it shows
24 up, but it isn't put separate although we have the
25 records to show how much credit we have received. We
26 get a credit note.

27 MR. WREN: Your records, I presume, would
28 be done by a chartered accountant?

29 MR. ISAACSON: That is right.

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2 MR. WREN: You are sure it does not show
3 as discount taken?

4 MR. ISAACSON: No, it might, if at the
5 end of the year -- you see, we don't get our commissions
6 from Drug Trading at the end of the year. We get them
7 in May and November. In November, for instance, it would
8 be only of purchases up to sometime in September. Our
9 auditor might calculate the expected credit.

10 MR. WREN: I have seen perhaps ten drug
11 statements, retail drug statements in the past three
12 months. I haven't seen any which show that discount
13 as part of the cost structure of the goods. It was in
14 each case shown as a discount taken, a part of the
15 ordinary....

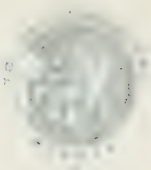
16 MR. ISAACSON: It wouldn't because if we
17 bought \$40,000.00 worth from Drug Trading in the year
18 we actually probably bought \$44,000.00.

19 MR. WREN: I understand that.

20 MR. ISAACSON: It wouldn't show.

21 MR. WREN: In the accounting you have to
22 show it as a revenue in one place or the other. It is
23 very essential to the cost of drugs where it is shown.

24 MR. ESTEY: I have a statement which is
25 filed as part of the survey which Mr. Isaacson is
26 talking about, a profit and loss statement for Mr.
27 Wilkinson's drug store. It might answer the question.
28 Across the foot of the profit and loss statement it
29 says: "Purchases reduced by patronage payments,
30 \$1,916.88". It just reduces the cost of the drugs.



MR. WREN: You are sure it does not show

as discount taken?

MR. ISAACSON: No, it might, if at the

end of the year -- you see, we don't get our commissions

from Drug Trading at the end of the year. We get them

in May and November. In November, for instance, it would

be only of purchases up to sometime in September. Our

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2 THE CHAIRMAN: It is actually reflected
3 in the statement?

4 MR. ESTEY: Yes.

5 THE CHAIRMAN: At least, in that state-
6 ment.

7 MR. ESTEY: Yes. I understand that is
8 the way it is handled because National Drug has to issue
9 a T-4 slip to the Department of National Revenue and
10 if nothing else that would keep the auditors honest.

11 MR. RICE: Are there a percentage of
12 your drugs that are wasted each year, that you have
13 to write off?

14 MR. ISAACSON: Oh there is a percentage
15 and each year when we take inventory, we will not count
16 drugs that we don't think are going to be useful, in
17 fact, we throw them out.

18 MR. RICE: In your operation at Lawrence
19 Park can you tell us what that would be approximately
20 for a year?

21 MR. ISAACSON: I would be guessing. It
22 wouldn't be large. It might be a couple of hundred
23 dollars, \$200.00 or \$300.00, \$500.00, something like
24 that.

25 MR. RICE: Do you follow the uniform
26 system or method of pricing your prescriptions in all
27 your eighteen to nineteen stores?

28 MR. ISAACSON: We follow the O.C.P.
29 pricing method.

30 MR. RICE: That is the method that was



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1
2 filed with the Committee yesterday. I noticed W.
3 Isaacson was the Chairman of the Committee of the
4 Council, Ontario College of Pharmacy in connection with
5 this. Is that yourself?

6 MR. ISAACSON: That is me.

7 MR. RICE: Perhaps, then, I could ask you
8 a question about this pricing. I understand it is
9 designed to two different methods, one drugs that are
10 compounded by the pharmacist and the other type of
11 prescriptions that is not compounded by the pharmacist.
12 Referring now to the type of prescription that is not
13 compounded by the pharmacist it appears that there is
14 a change at \$9.00 and also at \$15.00. For example,
15 taking a prescription of 12 units when you pay \$9.00
16 per hundred and dispense 12 units, according to the
17 price it is \$2.70. When you pay \$9.20 for one hundred
18 pills, whatever they are, and you dispense 12, you
19 charge \$2.50 which is a reduction in price although
20 you are paying more. Can you explain that jump back
21 at the \$9.00 figure?

22 MR. ISAACSON: I know that is hard to
23 explain. When the president of the Council of the
24 College of Pharmacy appointed the Committee as a special
25 Committee on prescription pricing and named me as
26 Chairman we inherited the old pricing method which is
27 quite similar to this because this type of method has
28 been in existence for a good many years. We didn't
29 change this pricing schedule. All we attempted to do
30 was to bring recommendations to keep it up to date.



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2 The only change that was made in the calculations was
3 to add 25¢ to the dispensing fee. It was 50¢. The
4 50¢ fee was built into the price for prescriptions.
5 In 1958, June of 1958 -- I have the record if you want
6 to read it, in the minutes of the College of Pharmacy
7 -- we attempted to do this and the Committee met and
8 studied ...

9 MR. RICE: I was wondering....

10 MR. ISAACSON: That is what the difference
11 is, what happened was when we got up to \$9.00, at \$9.00
12 the Committee felt it shouldn't continue with the
13 75¢, they should leave it at 50¢, so that the prices
14 started to drop back until it picked up further on.

15 MR. RICE: I notice \$15.00 there is also...

16 MR. ISAACSON: The same thing happened.

17 MR. RICE: The same thing.

18 MR. ISAACSON: The same thing.

19 MR. RICE: There is a dropback in price.

20 THE CHAIRMAN: Is there such a thing as
21 an advance in price to deal with the fashionable
22 carriage trade?
23
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1
2 This is not binding on you either on
3 minimums or maximums?

4 MR. ISAACSON: Not compulsory at all.

5 THE CHAIRMAN: Do you ever run into any-
6 body who felt better if he paid more?

7 MR. ISAACSON: We have never had any
8 complaints about our prices.

9 MR. RICE: I was just wondering Mr.
10 Isaacson if some of the members of the Committee
11 happened to notice that, if there is some explanation
12 for that.

13 MR. ISAACSON: It was bad. Actually it
14 is not a perfect method anyway, but we are just doing
15 the best we can with it because it is still intended to
16 be merely a guide to any pharmacist who wants to price
17 his prescription as fairly and as equitably as possible.

18 MR. RICE: Now in your experience in
19 Toronto here have you had any complaints about the
20 quality of the drugs that your stores have been providing?

21 MR. ISAACSON: We will not dispense any
22 drug of inferior quality. We want the best quality in
23 there and that is the only type of drugs we use in our
24 prescription. Never had any complaint in any way, shape
25 or form.

26 MR. RICE: About the price of your pres-
27 criptions, has anyone ever complained to you about the
28 price of your prescriptions?

29 MR. ISAACSON: No complaint.

30 MR. RICE: Not in any of the 18 or 19



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1
2 stores?

3 MR. ISAACSON: No.

4 MR. WREN: How do you determine quality?
5 How are you certain the quality is top?

6 MR. ISAACSON: That is a good question,
7 but over the years we have learned to rely on certain
8 established firms such as - do you want me to mention
9 names?

10 MR. WREN: Not necessarily, no.

11 MR. ISAACSON: And we know - I say we
12 know, we are just satisfied that these firms do maintain
13 the highest standard of purity, potency and accuracy in
14 dosage and keep right up to date in their assaying or
15 testing equipment or research, and so forth.

16 MR. WREN: When you make a definite asser-
17 tion that you are certain that the quality is top grade,
18 I depend on the L.C.B.O. but get some bad stuff once in
19 a while. I don't know.

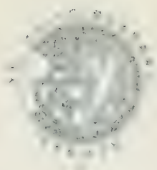
20 MR. ISAACSON: We pay more for L.C.B.O.
21 products than we do for others.

22 THE CHAIRMAN: Would it be fair to say
23 that there is another - nobody is perfect. At least I
24 am not but if someone made a mistake you would want to
25 deal with a man, if he did make a mistake who would be
26 willing to back up what he had done. Would that apply
27 in the drug business?

28 MR. ISAACSON: You mean a firm?

29 THE CHAIRMAN: Yes.

30 MR. ISAACSON: Pharmaceutical firms - well



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2 I remember some years ago, this doesn't happen very
3 often but it happens. There was one firm that called
4 in all its - all the drugs of that product. I just
5 can't remember the name but they asked every pharmacist
6 to return that particular product because they had
7 discovered that it wasn't up to standard and we got
8 full credit, of course, for it.

9 MR. WREN: So you rely entirely then on
10 the firm's reputation?

11 MR. ISAACSON: Yes.

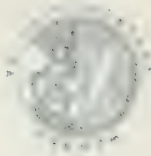
12 MR. RICE: In filling a prescription for
13 drugs, has the druggist much of a selection as to the
14 manufacturer that he will use in filling that prescrip-
15 tion?

16 MR. ISAACSON: No, not too much because
17 when the doctor orders a product we fill it exactly as
18 ordered. He mentions, for instance, achromycin, that
19 is what we give the patient, achromycin. Nothing else
20 and that means the doctor wants that particular product.

21 THE CHAIRMAN: If he said butone instead
22 of butazolidin you would give butone?

23 MR. ISAACSON: No, first of all I don't
24 think we would have it in stock. If we weren't sure
25 what the doctor wanted, in other words, if he was
26 looking for price, we would call him and check. Other-
27 wise, we would fill it with the quality product or the
28 product we feel is the quality product, butazolidin.

29 THE CHAIRMAN: But you check with the
30 doctor?



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THE CHAIRMAN: But you check with the



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2 MR. ISAACSON: We would check with the
3 doctor if it wasn't clear and I wasn't sure.

4 THE CHAIRMAN: Butone is different from
5 butazolidin isn't it? It's a different product.
6 Different manufacture isn't it?

7 MR. ISAACSON: I don't know.

8 THE CHAIRMAN: Of course it is. I take
9 it myself. Butone comes in the powder and capsule and
10 butazolidin is a little compressed tablet. They are
11 both used for arthritis.

12 MR. ISAACSON: I am not familiar with
13 it.

14 THE CHAIRMAN: Assuming you understood
15 the difference I am making to you between these two
16 products - one is made by one company and another by
17 another company.

18 MR. ISAACSON: If we received a prescrip-
19 tion for butone is that what you mean?

20 THE CHAIRMAN: Yes.

21 MR. ISAACSON: We would definitely, if
22 we did not have it, we would get it.

23 THE CHAIRMAN: Or report to the doctor?

24 MR. ISAACSON: Or call the doctor and
25 tell him we hadn't got it. If he tells us to use some-
26 thing else, we would.

27 THE CHAIRMAN: So you understand Mr.
28 Isaacson that this question is substitutional.

29 MR. ISAACSON: Never substitute.

30 THE CHAIRMAN: In fact, there is some

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THE CHAIRMAN: In fact, there is some



1
2 butone right there (indicating). That is what I mean,
3 a powder and a capsule.

4 MR. ISAACSON: I misunderstood your
5 question. I didn't know butone. I thought maybe you
6 were referring to it as a generic name for butazolidin.

7 MR. WHITE: May I ask a question on this
8 Mr. Chairman?

9 THE CHAIRMAN: Yes Mr. White.

10 MR. WHITE: First, have you noticed in
11 your personal experience any increase in the number of
12 generic prescriptions?

13 MR. ISAACSON: There has not been too
14 many. It's a small percentage.

15 MR. WHITE: A little increase in the
16 number of prescriptions using generic terms?

17 MR. ISAACSON: Some doctors I think are
18 trying to - put it that way, and depending on the
19 clinical experience which they may have, which they
20 may or may not have. We have had cases, these are
21 actual facts in our store where there were some pres-
22 criptions for generic type, cheaper type of drug by
23 generic name and it was dispensed. After two or three
24 repeats frankly the doctor got the information that it
25 was not helping or for some reason there was no improve-
26 ment in the ailment and he would call us and switch
27 over to the brand name. This may be a coincidence or
28 not but the very first prescription of the brand name
29 the patient recovered.

30 MR. WHITE: Almost every generic term has

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MR. WHITE: Almost every generic term has



1
2 a brand equivalent hasn't it? Likely several brand
3 equivalents?

4 MR. ISAACSON: If it's a generic drug
5 that the doctor had intended us to use, not the brand
6 name drug sold by some other firm ---

7 MR. WHITE: May I ask this question: if
8 you received a prescription describing the drug by its
9 generic term, and if you happened to have two brands
10 on your shelf, each of them be equivalent of the generic
11 drug required, would you feel obliged to supply the
12 lower price of the two drugs?

13 MR. ISAACSON: No, I don't think that
14 would actually happen. That is, there wouldn't be two
15 firms of what we call our established firms that would
16 have exactly the same drug. There are exceptions to
17 that too, such as Miltone and Equinol. These are two
18 different firms.

19 MR. WHITE: Are they exactly the same
20 chemical, those two products?

21 MR. ISAACSON: Yes. Same price too.

22 MR. BRYDEN: Taking an example there,
23 I have the drug index for 1960 which may be a little
24 out of date now. Under the heading Tetracycline Hydro-
25 chloride there are listed here seven brand names. Now
26 would I be right in assuming that those are the same,
27 at least they have the same basic ingredients in them
28 in all cases?

29 MR. ISAACSON: I think so.

30 MR. BRYDEN: If the doctor prescribed

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MR. ISAACSON: I think so.

MR. BRENNEN: If the doctor prescribed



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2 tetracycline hydrochloride and you have three or four
3 of these brands on your shelves, on what basis do you
4 make a selection?

5 MR. ISAACSON: It doesn't happen that
6 way actually. If we weren't sure which one he wanted,
7 we might assume that he wants a certain name.

8 THE CHAIRMAN: No, the point Mr. Isaacson
9 that is being made is that the prescription is written
10 in the generic language only with no reference to a
11 company or trade name. Is that not it Mr. Bryden?

12 MR. BRYDEN: Well I understand Mr. White
13 started the line of argument.

14 THE CHAIRMAN: There is a prescription
15 written by a generic name without reference to a company
16 or trade name. Then what happens?

17 MR. ISAACSON: We would use the one that
18 we would have which we know is top quality. That is,
19 it would have to be one of the firms -- if there are
20 seven, I don't know.

21 MR. BRYDEN: There are seven names here
22 and I think they give four firms.

23 MR. ISAACSON: If we feel that they are
24 all of the same quality, there might be a decision as
25 to which one to use or we have to call the doctor and
26 just tell him which one do you want? Ask him.

27 MR. BRYDEN: I am just wondering what
28 this situation does to your inventory problem because
29 the doctor probably doesn't prescribe by the official
30 name and generic name. He prescribes one of these

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2 brands listed. Now do you have to keep all brands on
3 your shelf?

4 MR. ISAACSON: If any prescription, you
5 see different doctors have different preferences. Some
6 like one firm, some like another and as these prescrip-
7 tions come in if we see there is a pattern here of
8 repeating this particular product we put it into stock,
9 if we didn't have it. We keep it in stock. We do have
10 four or five different firms with different names whose
11 products could be the same.

12 MR. BRYDEN: Any one of which may be
13 prescribed by a different doctor?

14 MR. ISAACSON: Yes.

15 MR. BRYDEN: Another complication appears
16 to me to arise, I look up, for example, achromycin which
17 is the first one in the index. Then I find there are
18 18 different ways in which achromycin is available. I
19 take it there is different methods of administering it.
20 Now that seems to me to really complicate your inventory
21 problem very seriously.

22 MR. ISAACSON: It does, but there is
23 nothing we can do about it because we must follow the
24 doctor's prescription strictly, to the letter.

25 MR. BRYDEN: But the effect could be that
26 your costs are increased, without getting into whether
27 it is a good thing or bad thing. It could have quite
28 an effect on costs?

29 MR. ISAACSON: It doesn't affect the
30 actual price of the prescription. The only thing is



brands listed. Now do you have to have all brands on

your shelf?

MR. ISAACSON: If you have a shelf, you

see different doctors have different prescriptions. Some

like one firm, some like another, and some prescribe

things come in if we see there is a common name

repeating this particular one, we put it into stock,

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2 that instead of having \$5 or \$6,000 invested, it's a
3 capital investment, our inventory will be \$9,000.

4 MR. BRYDEN: So therefore it means you
5 carry more on your inventory?

6 MR. ISAACSON: Just carry more. We would
7 rather carry more than be short; not have what the
8 doctor wants when he wants it.

9 MR. BRYDEN: It seems to me as a layman
10 to be rather a proliferation of brands here.

11 THE CHAIRMAN: I don't know that follows
12 at all. If you go into a certain large store and have
13 ten kinds of tomato juice, it is probable that that
14 store does ten times the volume of business that the
15 store does that carries one brand of tomato juice.

16 MR. BRYDEN: I doubt if they do ten times
17 the business. That is not what I was getting at Mr.
18 Chairman. I think the costs are increased by the fact
19 that they may have to carry ten brands of practically
20 identical products.

21 THE CHAIRMAN: Whose fault is that?
22 We might chat a little bit about that. Is that the
23 public's fault? The doctor's fault?

24 MR. BRYDEN: I think it may be a characteri-
25 stic of this particular type of market. It may be a
26 factor of increasing costs. It may ultimately be of
27 concern to us although not necessarily to this witness.
28 I don't think he in his position can do anything about
29 it.

30 MR. ESTEY: Mr. Chairman, would Mr.



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2 Bryden indicate to us those seven brand names. We may
3 have a look at them and see what the price paid is.

4 MR. BRYDEN: I am quoting from page 8 of
5 the Drug Index for 1960 and there is first of all the
6 main heading Tetracycline and then under that there are
7 three headings described as official names and the one
8 I am referring to is first tetracycline hydrochloride
9 and then brand names listed under that heading are
10 achromycin, achromycin V or five, I don't know which it
11 is, and tetracyn, cosa tetracyn, panmycin, polycycline,
12 petrex and then in brackets is the word prep. I don't
13 know what that means.

14 MR. ESTEY: It doesn't give the price?

15 MR. BRYDEN: No. This, as I understand
16 it is a guide for the dispensary. The gentlemen you
17 represent would understand the book much better than I
18 do.

19 MR. ESTEY: I think those are all the
20 same price.

21 MR. BRYDEN: My understanding is that
22 tetracycline has always been at the same price. Although
23 there are four producers they produce at identical
24 prices.

25 THE CHAIRMAN: That is not a subject
26 before this Committee.

27 MR. BRYDEN: No. The only point before
28 our Committee is that the druggist or the pharmacist -
29 how he exercises his choice in filling a generic pres-
30 cription.



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MR. SUTTON: You say you have been a practising pharmacist for 26 years and I would like your opinion on a matter that came up yesterday. Do you consider penicillin a dangerous drug to get into the hands of the public? Are you aware that penicillin is sold to farmers through the feed store?

MR. ISAACSON: We just heard that, that there was a new order-in-council, or whatever you call it, just recently the Ontario Government had amended the Pharmacy Act allowing the sale of these drugs through feed stores.

MR. SUTTON: Do you consider aspirin a dangerous drug to be in the hands of the public without a prescription? We heard yesterday that babies had died because of over-doses of aspirin?

MR. ISAACSON: Almost anything could be a dangerous drug if it is taken wrongly, and aspirin would come under that.

MR. SUTTON: What about boracic acid?

MR. ISAACSON: It is a poison.

MR. SUTTON: How many other drugs are sold by grocery stores?

MR. ISAACSON: A long list of what is called household drugs, which is allowed to be sold. The government passed some sort of an order-in-council, allowing these drugs to be sold in any store. Intention-wise that in very small towns and villages, which are

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MR. SUTTON: You say you have been a



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2 too small for a drug store, that the general store
3 could carry camphorated oil, iodine, and quite a number
4 of things.

5 MR. SUTTON: Has your organization been
6 active in trying to get amendments to the Pharmacy
7 Act, so that all these dangerous drugs would be sold
8 by prescription and administered or dispensed by
9 registered pharmacists?

10 MR. ISAACSON: We have been trying, but
11 sometimes, I am just expressing my own opinion here,
12 sometimes we feel we are not getting the sympathy of
13 the government, or there is just a deaf ear placed to
14 us in these submissions, amendments if you like, to
15 the Pharmacy Act in order to protect the public.

16 MR. SUTTON: I have been a member since
17 1955, and I haven't heard of it being brought before
18 this government at all, and I think it is criminal to
19 permit penicillin to be sold to farmers who administer
20 this to dairy cows. I was a farmer myself for 15
21 years, and I know something about it, and your organiza-
22 tion, as far as I am personally concerned has made no
23 move to get this drug administered under proper control.

24 MR. WREN: I well recall in 1953 when
25 the pharmacists made a strong protest --

26 MR. SUTTON: I say I have been a member
27 since 1955, and I have never heard of it.

28 MR. ISAACSON: For the last two years,
29 our College, Mr. Moisley, Registrar, and the Council,
30 have endeavoured to the utmost of their ability to get



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2 through to the government, and we are blocked right in
3 the department that has to do with this particular
4 legislation, and I think it is the Minister of Health's
5 department. They have turned a deaf ear to all our
6 pleas.

7 MR. SUTTON: Speaking personally, and not
8 for the Committee, I would like an opportunity to go
9 to bat for you.

10 MR. ISAACSON: We would appreciate it.
11 We feel it is in the interest of the public to prevent
12 these things from being used indiscriminately. We
13 heard that it is being studied in Great Britain, and
14 we asked them to hold this up until they get the report,
15 and they didn't. Now it is being put through. The
16 College was prosecuting Glydol products for selling
17 drugs indiscriminately and in violation of the Pharmacy
18 Act, and they kept remanding the case until this was
19 put through, and now we have had to withdraw the
20 charges against them.

21 MR. FULLERTON: Approximately how many
22 prescriptions could be filled by a pharmacist in one
23 hour?

24 MR. ISAACSON: If you want an average,
25 on the average it would be less than four, but in any
26 one hour, a pharmacist could fill maybe half a dozen
27 prescriptions, but in the next hour he may not fill
28 any.

29 MR. FULLERTON: If he was busy for an
30 eight hour day, approximately how many would he fill?



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2 MR. ISAACSON: The average per day, I
3 will quote this survey, 130 prescriptions a week. That
4 could be maybe 18, 19 on week days and maybe half a
5 dozen or so on Sundays if he was open five to six or
6 seven hours on Sunday.

7 MR. FULLERTON: I was checking your cost
8 on a drug of \$1.60, when you were losing ten cents, and
9 that would allow him \$130.00 salary, where you are
10 allowing him \$120.00 salary. My other question was
11 when I look at your net profit of \$2,916.00, have you
12 any explanation as to how these so-called cut-rate
13 drug stores show a profit and make a living?

14 MR. ISAACSON: I really have no informa-
15 tion on how they make a living. I have no idea. I
16 personally don't see how they can do it, because our
17 margin is so small as it is, at regular prices. Some-
18 thing has to be cut down somewhere in order to make a
19 profit at a lower price.

20 MR. PRICE: Where the prescription calls
21 for a generic term, what percentage would also include
22 specific manufacture in your experience?

23 MR. ISAACSON: I don't understand that.

24 MR. PRICE: When a prescription is in a
25 generic term, I understand it is quite frequently
26 specified in addition, the name of the manufacturer that
27 the particular doctor would prefer. It seems to me
28 we have heard that doctors prefer certain companies.
29 What percentage of those prescriptions would specify
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4 unpopular with the doctor. I went over our dispensary
5 last night after the questioning yesterday, to see what
6 would happen if doctors started to write by generic
7 term, and I know how they call up on the phone and say
8 take this prescription, and it is usually at a rapid-fire
9 rate. "Mrs. So and So, send her Pyr Vinium Pamoate
10 Suspension, Sulfa Methoxy Pyridazine, Ben Zydro Flu
11 Methiazide with Rauwolfia Serpentina & Pot. Chlor.
12 Send her 24, one three times a day." Bang! The
13 difference in that is a term like Vanquin, seven letters,
14 Midicel, Parke-Davis, Rautractyl. The manufacturers
15 specifically coin these words and make them short and
16 quick and clear, so that there is no mistake.

17 MR. BRYDEN: This is a matter of simpli-
18 fying the generic terms. There is no reason why a
19 simplified form couldn't be developed as a standard.

20 MR. ISAACSON: These are not the chemical
21 names. These chemical names are this long.

22 THE CHAIRMAN: Let us assume that we have
23 some numerical or some simplified form whereby all
24 drugs are compounded on a generic name basis with no
25 reference to a trade name or a brand name. I think the
26 relative point is what is the significant effect of that
27 on the price of the prescription.

28 MR. ISAACSON: I don't think it would
29 have any to the point where we would still want to
30 dispense the best quality of that particular generic drug.



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2 MR. BRYDEN: But you may only have to
3 carry in stock the one you consider best if it was
4 prescribed by a generic name, and you wouldn't have all
5 this competition on your inventory?

6 MR. ISAACSON: That is right, if the
7 products were manufactured by the firm exactly the same.
8 I am not talking of the equivalence. A lot of these
9 firms can change one molecule here and there, like
10 hydro-cortisone is different than cortisone, and it
11 makes tremendous difference to the side reactions it
12 might develop. One molecule of water for instance.

13 MR. BRYDEN: It gives them something of
14 a monopoly position if they have something slightly
15 different in basic --

16 THE CHAIRMAN: You are assuming that the
17 whole medical profession would swallow that, hook line
18 and sinker.

19 MR. BRYDEN: No, but if some of them are
20 persuaded it would be beneficial to the manufacturer,
21 and they are subject to a whole barrage of propaganda.

22 THE CHAIRMAN: That brings up the question
23 of who is not subjected to propaganda.

24 MR. BRYDEN: Often doctors are persuaded
25 to prescribe something that is considerably inferior --

26 THE CHAIRMAN: In other words, there is
27 a lazy aspect to most of us, but it is not confined
28 entirely to doctors. It might be lawyers or stenographers.

29 MR. BRYDEN: The doctors are like all of
30 us, victims of propaganda --

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THE CHAIRMAN: Do you think that any one of us could possibly keep up to date on any one subject?

MR. BRYDEN: That is why a manufacturer can create a monopoly --

THE CHAIRMAN: Don't we have to assume that professional people are basically honest?

MR. BRYDEN: Yes, but they are capable of being misinformed too.

THE CHAIRMAN: What is the relevancy of that point? All of us may be misinformed, whether in a dentist's office or a real estate office.

MR. BRYDEN: Because the fact that that situation exists makes it possible for a manufacturer to create a partial monopoly for himself, by selling doctors on his brand name as opposed to the other.

THE CHAIRMAN: To get at the effect of that, you would have to measure any price difference that might exist, and the volume of business done, and the number of people affected, wouldn't you?



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MR. BRYDEN: Well, it tends to create a pretty marked monopoly situation.

THE CHAIRMAN: Isn't the question ultimately whether it does create a marked monopoly?

MR. BRYDEN: That is a big question. I think that is something we have to go into. My conclusion is that it does.

THE CHAIRMAN: Let's look at the College recommended schedule of fees, Mr. Isaacson. I don't know anything about this book, how you apply it, but it is apparently in use in some areas, and I gather it is an accepted base of pricing, is it a general base of pricing. There are other schedules higher and others lower.

MR. ISAACSON: Yes, in different towns and cities. Hamilton, for instance, have developed their own.

THE CHAIRMAN: I don't know enough about this subject to detail the question, but could you pick an item which is available in your store under a generic name only that you could supply as a generic so-called, and that must be one that is on your shelf as a trade or brand name. Could you pick some item and tell us firstly the difference in price of the raw material and the difference in price in the net result to the patients?

MR. ISAACSON: Difference between brand names and the generic, the difference in price?

THE CHAIRMAN: Yes.



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THE CHAIRMAN: Yes.



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2 MR. ISAACSON: And some other supplier
3 under the generic name?

4 THE CHAIRMAN: Yes, where you have it as
5 a generic and try to see what the ultimate result would
6 be and any difference.

7 MR. ISAACSON: If I had known I would have
8 gotten the equivalent price on, say, meprobanate. But
9 there might be something in this which would help. I
10 have Mr. Gilbert's synopsis here from the Select
11 Committee hearings, his brief.

12 THE CHAIRMAN: Do you purchase from Mr.
13 Gilbert?

14 MR. ISAACSON: Oh, I don't think so.
15 It may be only one or two items, because we don't get
16 many calls for it. Perhaps I can use his figures to
17 illustrate this thing.

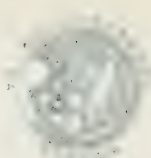
18 MR. WREN: Why would you use his figures
19 if you were not using his products?

20 MR. ISAACSON: I just copied this from
21 the Select Committee hearings. Here is equanil:
22 Generic \$4.00. It was \$6.00, it is now \$5.00, and
23 generic is \$4.00.

24 THE CHAIRMAN: What would the average
25 prescription be?

26 MR. ISAACSON: If it was the full bottle,
27 the full package. Incidentally, 50% of our prescriptions
28 are filled in the original packages, a full package.

29 THE CHAIRMAN: The average would be 25,
30 would it? If 50% of your prescriptions are filled in



MR. ISAACSON: And some other supplier

under the generic name?

THE CHAIRMAN: Yes, where you have it as

a generic and try to see what the ultimate result would

be and any difference.

MR. ISAACSON: If I had known I would have

gotten the equivalent price on, say, meperidine. But

there might be something in this which would help. I

have Mr. Gilbert's synopsis here from the Select

Committee hearings, his brief.

THE CHAIRMAN: Do you purchase from Mr.

MR. ISAACSON: Oh, I don't think so.

It may be only one or two items, because we don't get

many calls for it. Perhaps I can use his figures to

illustrate this thing.

MR. WREN: Why would you use his figures

if you were not using his products?

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the Select Committee hearings. Here is example:

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are filled in the original packages, a full package.

THE CHAIRMAN: The average would be 25,

would it? If 50% of your prescriptions are filled in



1 the full bottle, the average must be half a bottle.

2
3 MR. ISAACSON: 20, a quarter, and at
4 \$4.00 it would be \$4.75, because all we would add on
5 there is the 75¢ dispensing fee, and the equanil would
6 be \$5.75. 12 of metrobanate, \$1.60, for 12; on the
7 equanil \$1.85.

8 THE CHAIRMAN: For 25?

9 MR. ISAACSON: On the metrobanate \$2.20,
10 \$2.55.

11 THE CHAIRMAN: I wonder if we might have
12 five minutes' recess.

13
14 ---A short recess.

15
16 THE CHAIRMAN: Mr. Rice?

17 MR. RICE: Mr. Isaacson, as the Chairman
18 of the Special Committee on Prescription Pricing for
19 the Ontario College, and bearing in mind that you have
20 some knowledge of the factors that go into their pricing
21 of prescription, and assuming that the hospital can
22 dispense the average prescription, \$3.30 at cost, could
23 I summarize some of the factors you would have to take
24 into consideration in your invoice and prescription
25 pricing that the hospital would not. The first would
26 be the sales tax of approximately 10%.

27 MR. ISAACSON: 11%.

28 MR. RICE: And there would be the mark-up
29 that we heard about that you would have to take into
30 consideration in your prescription pricing of approximately

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 MR. ISAACSON: 20, a quarter, and at
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 be \$2.75. 12 of metopranolol, \$1.60, for 12; on the
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 be the sales tax of approximately 10%.

MR. RICE: And there would be the mark-up

that we heard about that you would have to take into

consideration in your prescription pricing of approximately



1
2 40%.

3 MR. ISAACSON: That is right.

4 MR. RICE: And then there would be the
5 prescription fee that you add on; is that correct?

6 MR. ISAACSON: Yes.

7 MR. RICE: And I believe you said that
8 is about 75¢?

9 MR. ISAACSON: 75¢. That is up to \$9.00.

10 MR. RICE: And then there is the cost of
11 the drug to the pharmacist, and one would have to
12 compare this with the cost of the same drug to the
13 institution, and if the institution bought from the
14 manufacturer direct, and then there would be the
15 wholesaler's discount, would there not?

16 MR. ISAACSON: Yes. I would say the
17 wholesaler receives a special discount from the
18 manufacturer.

19 MR. RICE: So if the institution could
20 purchase at wholesale prices, then the institution
21 could save that as well, whereas you would have to
22 pass that along. Have you any idea what the discount
23 is to the wholesaler?

24 MR. ISAACSON: I believe it is around
25 16-2/3% there.

26 MR. RICE: Also can institutions make
27 special deals because of the quantities they purchase?
28 Can they get quantity discounts that the ordinary
29 pharmacist could not take advantage of?

30 MR. ISAACSON: My impression -- I haven't



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MR. ISAACSON: My impression -- I haven't



1 seen any of their figures -- is that in selling their
2 products to hospitals there is an entirely different
3 type of pricing. The manufacturer may sell even at
4 their cost just to get the distribution.
5

6 MR. RICE: Would that cost be lower or
7 higher than they sell to the retail pharmacists?

8 MR. ISAACSON: Considerably lower.

9 MR. RICE: If we take your average
10 prescription of \$3.30 and a patient obtaining that
11 prescription in a hospital, and if it was given at
12 cost to the hospital and the same patient had to purchase
13 that prescription outside at one of your stores, can
14 you give us an idea as to what the difference in price
15 would be?

16 MR. ISAACSON: Perhaps Mr. Keating or
17 Mr. Wilkinson may have some information on that.

18 MR. KEATING: A hospital is not allowed
19 to dispense a prescription and charge for it. Employees
20 in the hospital, and so on, that prescription is taken
21 to the pharmacist. They cannot give any medication
22 out under the Ontario Hospital Services. It cannot
23 be done.

24 MR. RICE: I have a hypothetical situation
25 here. I am assuming what the cost to the hospital is
26 in regard to that particular prescription, which is
27 going to be included in the patient's account.

28 MR. KEATING: It depends what the hospital
29 pays for medication, because they do get a much lower
30 rate.



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2 MR. RICE: There is a great difference
3 between the two prices.

4 MR. ISAACSON: I would say there was no
5 relationship between the two.

6 MR. RICE: Just on discounts alone there
7 would be 66-2/3%, would there not?

8 MR. ISAACSON: I don't know.

9 MR. ESTEY: Perhaps Mr. Keating could
10 deal with that when he is in the stand.

11 MR. RICE: Any other questions from the
12 members?

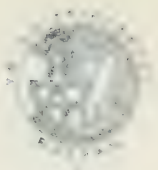
13 MR. WREN: Did not a witness tell us
14 yesterday or the day before it was possible to get a
15 prescription from a hospital, filled in some hospitals
16 in Toronto, people in straitened circumstances.

17 MR. RICE: I understood there were some
18 indications that hospitals passed along their cost to
19 the patients?

20 MR. WREN: Mr. Keating suggests it is
21 prohibited.

22 MR. KEATING: I am just saying that we
23 may not dispense to anyone in the hospital or a patient
24 within the hospital. If they are released from hospital
25 they are given a prescription to be filled at their
26 own pharmacy.

27 MR. ISAACSON: Mr. Chairman, may I be
28 permitted to correct some of the figures that I gave
29 you in connection with that comparison of prices?
30 I haven't been dispensing for a while and it escaped me.



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4 it, whereas it only had 50. So when you asked for a
5 price on 12, it would not be an eighth, it would have
6 been a quarter, and when you asked for the price on
7 25, it would have been half.



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2 THE CHAIRMAN: Would you correct the
3 record and give us an accurate statement of the figures
4 as you show them?

5 MR. ISAACSON: Yes, the original bottle
6 prices...

7 THE CHAIRMAN: Bear in mind, Mr. Isaacson,
8 when the record comes up we want to be able to read it
9 and understand it. You are always talking to the record.

10 MR. ISAACSON: Well then, the original
11 bottle at \$4 with the generic name...

12 THE CHAIRMAN: For 100?

13 MR. ISAACSON: For 50.

14 THE CHAIRMAN: For 50.

15 MR. ISAACSON: Is \$4.75, and the brand
16 name is \$5.75 in the same quantity. Then, half a
17 bottle, if the prescription is for half, the generic
18 item would cost \$3.15 and the brand name product would
19 be \$3.75. The quarter-size, if one-quarter was pres-
20 cribed the generic item would cost \$2.20 and the brand
21 name produce would be \$2.55.

22 MR. WREN: I have one question, Mr.
23 Isaacson, you operate approximately 19 stores?

24 MR. ISAACSON: I am associated - I have
25 pharmacists who are partners.

26 MR. WREN: How many pharmacists in all
27 would you employ in all these stores, aggregate pharma-
28 cists?

29 MR. ISAACSON: Two pharmacists for a store.

30 MR. WREN: About 35 - 34, 36.



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MR. ISAACSON: 19 stores would be 38.

MR. WREN: How many of these are women?

MR. ISAACSON: I was going to say none,
but we have one.

MR. WREN: Are there very many in the
profession generally?

MR. ISAACSON: There is quite a number,
but I wouldn't say - I don't know how many are in the
retail stores. A number would be in other branches
like hospital pharmacies.

MR. WREN: Have you any knowledge how
many might be in training?

MR. ISAACSON: Pardon?

MR. WREN: Have you any idea how many
might be in training each year?

MR. ISAACSON: That I don't know. I
could get the figures. Mr. Moisley might have them.

MR. FAIRLEY: I am G.W. Fairley. I am
field extension officer of the Ontario College of Pharmacy.
As such I am in charge of recruiting. At the present
time we have approximately 400 students enrolled in
the four years. Approximately 100 are ladies, and that
number is constantly increasing, steadily increasing
in the last four years.

MR. WREN: How many will graduate this
year?

MR. FAIRLEY: How many ladies?

MR. WREN: Yes.

MR. FAIRLEY: About 14 will obtain full

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MR. FAIRLEY: Yes.

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2 standing and about three or four will have conditions
3 that they will have to write off in the fall.

4 MR. WREN: That is out of how many, a
5 total of 120?

6 MR. FAIRLEY: Out of a total of 71.

7 MR. WREN: 71?

8 MR. FAIRLEY: 71 graduating, 71 in the
9 graduating class, 56 in full standing and 15 with
10 conditions.

11 MR. BOYER: Are the classes smaller than
12 they used to be?

13 MR. FAIRLEY: Yes, a little smaller.
14 Last year we had 63 graduating outright and this year
15 was 56. The number is increasing. In the first year
16 we have enrolled 120. The third year has an increased
17 number which is larger than the graduating class,
18 increasing until we reach a total of 123 in first year.

19 MR. TROTTER: Mr. Isaacson, would you
20 know the women in your work, do they get equal pay for
21 equal work?

22 MR. ISAACSON: Yes.

23 MR. TROTTER: You mentioned you hadn't
24 heard many complaints or any complaints, I think you
25 said, about prices in your stores. Would the prices
26 for prescribed drugs be cheaper in your stores as a
27 result of your being associated with other stores?

28 MR. ISAACSON: No.

29 MR. TROTTER: It makes no difference?

30 MR. ISAACSON: No.

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MR. TROTTER: Do you find a chain of stores, say like Tamblyn's, would sell drugs cheaper than you would?

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MR. ISAACSON: No, I don't see how they could. Their overhead would be just as much, if not more.

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MR. TROTTER: Then, there would be no advantage in buying in large lots by a drug company, having a large number of stores and ordering in large lots from a central buying agency? Is there any advantage in that?

13

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MR. ISAACSON: There are some items. You might count them on one hand or both hands. It is not usual in drugs. If you are talking about other merchandise...

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MR. TROTTER: I am just interested in drugs.

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MR. ISAACSON: In drugs there are some, a few items one could buy 50,000 if they could use 50,000.

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MR. TROTTER: It would seem to me that the hospitals can buy drugs more cheaply possibly because of their size. Would there be that great difference between a hospital ordering drugs from a manufacturer and a large retail chain ordering drugs?

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MR. ISAACSON: I would say that the prices to the hospitals would still be lower, no matter what quantity the retailer would buy.

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1 something to do with it?

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3 MR. ISAACSON: Only just isolated cases,
4 in general it just doesn't happen that way. You can't
5 buy that much because we could be, to use a common
6 expression, stuck with it.

7 MR. TROTTER: I can understand smaller
8 retailers being stuck. Again, I am thinking of the
9 ability to buy in quantity if small druggists worked
10 together in some type of co-op., they could buy in
11 quantity and cut costs.

12 MR. ISAACSON: They could in some cases,
13 but it is not a general practice.

14 MR. TROTTER: It may not be the practice
15 but is there something about drugs different from
16 buying anything else?

17 MR. ISAACSON: At all times we have to
18 be careful we don't have too much of any drugs, parti-
19 cularly the high-priced ones because we don't know how
20 long the doctors are going to keep the prescriptions
21 on. Once they stop we are left with whatever we have
22 got in.

23 THE CHAIRMAN: For example you could buy
24 two carloads of toilet paper and next year it is just
25 as good, but you cannot very well buy two carloads of
26 a drug.

27 MR. ISAACSON: That is correct.

28 MR. TROTTER: I still don't quite under-
29 stand that. If you had a market, either a number of
30 small pharmacists going together or a large chain they



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MR. ISAACSON: It would involve a lot of
work on somebody's part to do this, to actually work
this out for them and do the buying and distributing
and collecting. It would involve quite a bit of time
on somebody's part.

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MR. TROTTER: Possibly, yes, but...

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MR. ISAACSON: It is not being done to
that extent in drugs. It is being done in general
merchandise, but not in drugs.

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MR. TROTTER: I was wondering why it
couldn't be. I realise it is not being done.

15

16

MR. ISAACSON: I think it would be pretty
risky.

17

18

MR. BRYDEN: Mr. Isaacson, would you say
the retail pharmacy field is overcrowded?

19

MR. ISAACSON: Pardon?

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21

MR. BRYDEN: Would you say the retail
pharmacy field is overcrowded?

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MR. ISAACSON: I really don't know.

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MR. BRYDEN: As I understand the evidence
we have heard - unfortunately I missed part of the
story yesterday, but I heard two very interesting briefs
from Mr. Wilkinson and your evidence. I think 20% of
the business on an average in a drugstore is actual
pharmacy, and the rest of it is on a small-scale depart-
ment store.

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pharmacy field is overcrowded?

MR. ISAACSON: I really don't know.

MR. BRYDEN: As I understand the evidence
we have heard - unfortunately I missed part of the
story yesterday, but I heard two very interesting briefs
from Mr. Wilkinson and your evidence. I think 20% of
the business on an average in a drugstore is actual
pharmacy, and the rest of it is on a small-scale depart-
ment store.

MR. ISAACSON: I think those that are in



1
2 business would certainly be glad to see a smaller
3 number, hoping they would gain - we would do more
4 prescription business, but this being a democracy there
5 is no way of passing laws to zone areas that only so
6 many drugstores can be in that area. I know they have
7 established that in Europe for many, many years, where
8 only one drugstore is allowed to be in that area for
9 so many thousands of people. The free enterprise system
10 here does not permit that.

11 MR. BRYDEN: I am not suggesting that,
12 I am trying to get at the facts of the matter.

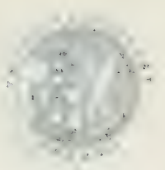
13 MR. ISAACSON: It is unfortunate.

14 MR. BRYDEN: There seems to be an over-
15 abundance of drugstores, possibly as a heritage from
16 an earlier period when transportation was less available
17 to most people than it is now.

18 MR. ISAACSON: We still see drugstores
19 open up between two other drugstores. It is happening
20 in...

21 MR. BRYDEN: I gather from Mr. Wilkinson's
22 brief there are some on the market for sale with no
23 buyers.

24 MR. ISAACSON: Certainly, certain loca-
25 tions. In fact there is some in Toronto. Your point
26 is well taken here. In Toronto we have 660 drugstores
27 and there are a good number of them that, perhaps,
28 don't make more than \$66,000-worth a year. As I have
29 pointed out in this schedule B that I have submitted
30 here, and those stores are not finding it very easy to



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don't make more than \$50,000-worth a year. As I have

pointed out in this schedule B that I have submitted

here, and those stores are not finding it very easy to



1 maintain a livelihood.

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3 MR. WREN: From your experience as,
4 perhaps, a chain operator, would you be in the drug
5 business at all on that scale were it not for general
6 merchandise?

7 MR. ISAACSON: We couldn't stay in busi-
8 ness.

9 MR. WREN: You couldn't stay in business
10 as a chain without general merchandise?

11 MR. ISAACSON: We couldn't stay in busi-
12 ness as a single unit if we didn't have the general
13 merchandise to make up the constant overhead.

14 May I be permitted to quote this, Mr.
15 Chairman, on this average schedule that I presented
16 here. A store doing \$105,000 is a good store. As I
17 have said there are a lot of stores that do less than
18 that. Then, there are stores that do \$300,000-worth
19 of business, but on the average the gross profit of
20 32% - that is pretty constant. It could be less. The
21 salaries are fairly constant, 19% of sales, \$20,000;
22 general overhead, 9 to 10% is quite constant, which is
23 \$29,540 on a gross profit of \$33,760. This is in the
24 entire store, leaving net profit of \$4,220, which is
25 4% of the total sales.

26 The breakdown of the prescription depart-
27 ment which was 20.9% of total sales, an average of
28 6,678 prescriptions a year at \$3.30 is \$22,037. The
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MR/hm

1
2 It's based on 40 hours a week at \$135.00
3 a week times 52 and the portion of general overhead
4 charged to the prescription department is based on
5 9% of the prescription income or 1.9% of total sales
6 which is \$1,983.00 making a total expense for the
7 prescription department of \$9,003.00, leaving a net
8 profit in the prescription department of \$2,016.00.

9 MR. WREN: You are charging a pharmacist
10 salary to the prescription department?

11 MR. ISAACSON: Half of it.

12 MR. WREN: Half of it, 50%.

13 MR. ISAACSON: The other half he has to --

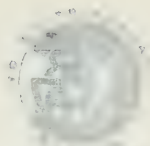
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15 of your volume of your business is not done in the
16 pharmacy.

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19 MR. ISAACSON: Because he has to spend
20 that time in the prescription department. The prescrip-
21 tions don't come in --

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23 this Mr. Isaacson. He does perhaps during your opening
24 hours spend some major time in the prescription
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6 3 point something per hour which adds up to about 40
7 hours a week that he has to spend in the prescription
8 department whether he fills prescriptions or not.

9 MR. WREN: I have in mind areas where
10 issuing prescriptions becomes somewhat automatic due
11 to distances from sources of supply. In other words,
12 it's the prescription issued in packaged form that you
13 were talking about a little while ago. The doctor
14 will order something that is packaged in 12 item units
15 and in those cases they are issuing prescriptions quite
16 rapidly; takes a matter of a second, taking it off the
17 shelf, labelling it, checking to make sure that it is
18 the proper item and issuing it. I know of stores where
19 that represents over 90% from their pharmacy turnover.
20 It doesn't follow that it takes 15 minutes to fill a
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22 MR. ISAACSON: We could fill more
23 prescriptions, but the average pharmacist can only fill
24 them when they come in the store. Sometimes an hour
25 or two can go by in the drug store and no prescriptions
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3 people who are spending or taking the risk rather of
4 going out of business because they have to be in
5 general merchandising instead of in a profession.

6 MR. ISAACSON: Well it has been going on
7 for over a hundred years Mr. Wren with the drug store.

8 MR. WREN: Tell me as a matter of interest
9 what is the general practise in Britain.

10 MR. ISAACSON: In Britain?

11 MR. WREN: Does the druggist carry on
12 other lines of business as well?

13 MR. ISAACSON: Yes, the drug stores there
14 do carry a lot of general merchandise. I wouldn't say
15 it is quite on the American type as we know it but most
16 of the items are similar. Of course they fill I think
17 about three times as many prescriptions now as they
18 did before the government went into the health scheme,
19 National Health Scheme.

20 THE CHAIRMAN: The health scheme boomed
21 it?

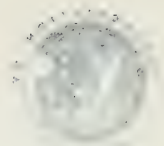
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24 MR. BRYDEN: Are your people in favour
25 of a health scheme here?

26 MR. TROTTER: I have been dying to ask
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28 MR. BRYDEN: It would seem it is rather
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3 this afternoon may have had to do particularly with the
4 what we call high priced drugs but for your information
5 the largest percentage of our dispensing is done in
6 the low priced field. It has nothing to do with these
7 high priced field, antibiotics and generic drugs. 80%
8 of our prescriptions are filled at \$5.00 or less.
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10 MR. BRYDEN: What sort of thing would
11 this be? I realize that there would be a great variety
12 in items. Could you give us two or three examples of
13 prescriptions that might be say less than your average
14 prescription price?

15 MR. ISAACSON: Yes, Phenobarbital tablets,
16 might charge \$1.15 for a prescription, takes just as
17 long for the pharmacist to fill it as a \$10.00 one.

18 MR. BRYDEN: That tends to make the
19 average a little misleading doesn't it? It is true
20 that the average is proportionate but there are some
21 items that are very high. They are the ones that cause
22 concern.

23 THE CHAIRMAN: And some that are very
24 low. I mean this is the meaning of the word "average"
25 isn't it?

26 MR. BRYDEN: I agree. It's just that
27 average is a little misleading.

28 THE CHAIRMAN: Not if you know the
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4 THE CHAIRMAN: 80%?

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8 MR. BRYDEN: Then 20% brings the average
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14 prescriptions are dispensed from these high priced
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17 these drugs, because of the price.

18 MR. WREN: Would it appear a radical
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20 be better employed at specified local occupations where
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24 MR. BRYDEN: You are not advocating
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26 MR. WREN: Would you think it desirable
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6 MR. WREN: It would be all right to meet
7 the public. Some of us have to.

8 MR. BRYDEN: It seems rather an
9 inefficient use of highly trained personnel though to
10 have them spending a substantial portion of their time
11 distributing cigarettes and such things which much less
12 qualified people can handle just as well.

13 MR. ISAACSON: That is true.

14 MR. BRYDEN: There is one firm in Toronto
15 and I know of possibly others that sell nothing but
16 drugs, as I understand it.

17 MR. ISAACSON: Well I wouldn't say nothing
18 but.

19 MR. BRYDEN: Very limited range beyond
20 the dispensing of drugs.

21 MR. ISAACSON: They are few and far between
22 and only operate economically in large metropolitan
23 areas. There are many, eight or ten prescription
24 stores where they do 80% of their business in prescriptions.
25 They don't need as much volume, for one thing.

26 THE CHAIRMAN: There is one in West
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28 MR. ISAACSON: There is one down in the
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3 MR. TROTTER: Have there been very many
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5 within the last two years?

6 MR. ISAACSON: They don't go bankrupt
7 Mr. Trotter. They just close up. They are not bank-
8 rupt. They pay their bills and get all their stock out,
9 sell off the stock to some other pharmacists with the
10 prescription file. This is happening quite frequently
11 and that is the end of it.

12 MR. TROTTER: One question about the
13 price of drugs. Would you say that most of the drugs
14 concerning the ills of old people of mental disease
15 or arthritis would be well above what you have called
16 the average price?

17 MR. ISAACSON: No, on the average, if we
18 are talking of this category, I might say that the
19 average per capita for prescriptions in Ontario is
20 seven fifty.

21 MR. TROTTER: That is for all the people
22 in Ontario?

23 MR. ISAACSON: Yes. Figure it out for
24 every person, seven fifty, roughly little over two
25 prescriptions per person per year.

26 MR. TROTTER: Of course, there again,
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28 MR. ISAACSON: They can be, yes.

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5 so forth. I would say this: That ever pharmacist that
6 wherever he can pass on or reduce the price to anyone
7 who is not in a position to pay, he will do so voluntarily.

8 MR. WREN: Yes, that is if you have
9 knowledge of it but you don't have the facilities to
10 know whether a person is in tough circumstances or
11 not.

12 MR. ISAACSON: They soon tell us. We have
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14 going to cost? It will cost \$10.00, if it happens to
15 be that price. Can you do anything for me? It happens
16 quite frequently. We say yes, how would it be if we just
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18 It happens quite frequently. Every pharmacist has to
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20 MR. TROTTER: Mr. Isaacson in the last
21 few years, let's say the last two or three years have
22 the pharmacists through any organization tried to bring
23 pressure upon drug manufacturers to reduce their price?
24 As a group tried to bargain with the drug manufacturers
25 to reduce their prices?

26 MR. ISAACSON: I am not aware of it. I
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28 MR. TROTTER: I asked that because it would
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2 THE CHAIRMAN: Mr. Trotter, isn't that
3 simply because he is low man on the totem pole?

4 MR. TROTTER: Yes, but like the workmen
5 he might get into a union and bargain with the boss,
6 possibly the pharmacists might do likewise with a drug
7 manufacturer. I realize that is their problem of the
8 pharmacist, he is the low man on the totem pole. I
9 thought they might want to do something about it.

10 THE CHAIRMAN: What about National Drug
11 and the Drug Trading Company? Weren't they designed
12 for that purpose?

13 MR. ISAACSON: National Drug?

14 THE CHAIRMAN: Drug Trading, wasn't it
15 formed to create the benefits, or to secure the benefits
16 of mass buying?

17 MR. ISAACSON: Yes, 50 odd years ago
18 because at that time retailer was paying a higher price
19 to the wholesaler to supply --

20 MR. WREN: But what proportion, what
21 per cent of your purchases from Drug Trading would be
22 prescription drugs? Prescription items?

23 MR. ISAACSON: I would be just guessing
24 Mr. Wren. I would have to figure that out.

25 MR. WREN: Is it a major proportion?
26 Major per cent?

27 MR. ISAACSON: No, it couldn't be for
28 our total purchases represent 20% of our total volume,
29 our total sales. Therefore, our purchases would be
30 proportionately less.



THE CHAIRMAN: Mr. Trotter, isn't that

simply because he is low man on the totem pole?

MR. TROTTER: Yes, but like the workmen

he might get into a union and bargain with the boss,

possibly the pharmacists might do likewise with a drug

manufacturer. I realize that is their problem of the

pharmacist, he is the low man on the totem pole. I

thought they might want to do something about it.

THE CHAIRMAN: What about National Drug

and the Drug Trading Company? Weren't they designed

for that purpose?

MR. ISAACSON: National Drug

THE CHAIRMAN: Drug Trading, wasn't it

formed to create the benefits, or to secure the benefits

of mass buying?

MR. ISAACSON: Yes, 50 odd years ago

because at that time retailer was paying a higher price

to the wholesaler to supply --

MR. WREN: But what proportion, what

per cent of your purchases from Drug Trading would be

prescription drugs? Prescription items?

MR. ISAACSON: I would be just guessing

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MR. WREN: Is it a major proportion?

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2 MR. WREN: That would be assuming you
3 get everything from Drug Trading?

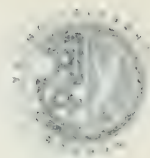
4 MR. ISAACSON: And Drug Trading supplies
5 a large percentage of general merchandise so the
6 percentage may come out somewhere --

7 MR. WREN: So actually the main benefit
8 of your co-operative buying from Drug Trading passes on
9 to other than prescription items in dollars?

10 MR. ISAACSON: Yes, and that reflects
11 itself in our 32% gross profit.

12 MR. WHITNEY: Mr. Chairman, I would like
13 to ask Mr. Isaacson of the proportion of their high
14 priced drugs, I think it is 10% of all prescriptions,
15 could you give any idea as to the percentage that is
16 dispensed to people of chronic conditions and where there
17 are a number of repeats would extend over quite a long
18 period of time, what percentage would you say that they
19 might be?

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2 MR. ISAACSON: I don't know. Our regular customers
3 could be, some of them could be people with chronic
4 conditions, who are coming in all the time, but again
5 I must say that wherever we go we often voluntarily
6 do, if they do get these over and over again, regard-
7 less of the quantity, we would offer them a special
8 price if they are going to be taken for some time.

9 MR. WHITNEY: I received a letter from
10 a person who had acquired some type of a liver extract,
11 and it is costing them a huge sum of money at regular
12 intervals, and I do feel that perhaps it is cases such
13 as that that have caused the greatest concern and the
14 greatest sympathy, that people even of moderate means,
15 after a period of years their means are depleted if
16 they are faced with a similar situation, so if we could
17 come up with a solution of some type to even endeavour
18 to see to it that those people with this chronic condi-
19 tion were able to be supplied with the drugs much more
20 cheaply over a period of time, even less than you can
21 do for them, it would be a great thing.

22 MR. ISAACSON: Well, you know that in
23 Australia and New Zealand there is a list of drugs
24 like that that are supplied free. The pharmacist fills
25 the prescription and sends the bill to the Government.

26 MR. WREN: Have any of your suppliers
27 ever said to you as a chain operator that they would
28 be willing to supply drugs for customers that may be
29 indigent or in somewhat straitened circumstances?

30 MR. ISAACSON: They have never offered it.



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2 THE CHAIRMAN: Have they ever done it?

3 MR. ISAACSON: Not to my knowledge.

4 THE CHAIRMAN: We have spent considerably
5 more time than we anticipated with Mr. Isaacson,
6 possibly it is a reflection on your great fund of know-
7 ledge.

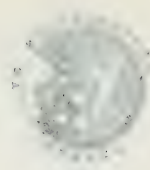
8 It does leave us towards the hour of
9 five o'clock, and it also leaves us with the cross-
10 examination of Mr. Wilkinson and of Mr. Rubin.

11 It would be my view that these gentlemen,
12 having attended faithfully for two solid days, and
13 there is also Mr. Keating, from Sarnia, having attended
14 for two solid days, that it would be an imposition to
15 ask them to carry on tomorrow, and I wonder if we
16 couldn't just adjourn this portion of the examination
17 to a later date, maybe a couple of weeks hence, and
18 pick it up from there, having in mind also that we are
19 bringing other people from a somewhat further distance
20 tomorrow morning.

21 Would that meet with your approval?

22 MR. ESTEY: I think so, but perhaps I
23 should consult with the gentlemen concerned. They
24 would rather come back tomorrow and get it over with,
25 but if the Committee is not going to sit, they are of
26 course at your disposition. We have a limited purpose
27 in introducing the kind of evidence we intend to. Mr.
28 Keating has been familiar with the hospitals, and that
29 might trigger off a great deal of questioning.

30 Mr. Wilkinson has some information



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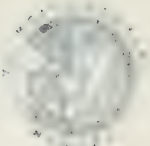
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2 arising out of questions which have not been fully
3 answered.

4 THE CHAIRMAN: I think we should adjourn
5 temporarily the retail druggists' presentation, and
6 the Secretary should try and arrange to bring them back
7 at a time which meets their convenience, so that we can
8 go on tomorrow with the ones from Montreal and New York.

9 Our job is not to inconvenience you
10 gentlemen. If you think this is hard work, it is also
11 hard work for us.

12 Thank you for coming, and Mr. Isaacson
13 thank you for your help.

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15 --- Hearing adjourned at 5:00 p.m.
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Select Committee on Drugs

HEARINGS

HELD AT
PARLIAMENT BUILDINGS
TORONTO ONTARIO

VOLUME No.: 19 DATE:

19

JUNE 9 1961

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Friday,
the 9th day of June, 1961,
at 10:30 a.m.

COMMITTEE:

MR. N. WHITNEY -- Acting Chairman

MR. A. WREN

MR. J.A. FULLERTON

MR. J. TROTTER

MR. R. E. SUTTON

MR. R.J. BOYER

MR. H.J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G.F. LAVERGNE

MR. S.J. GADSBY, F.C.I.S., Secretary

MR. HAROLD A. RICE -- Committee Counsel

MR. W.J. AYERS -- Accounting
Consultant to the
Committee



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MR. K. BRYDEN

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MR. J. J. McLELLAN

MR. J. J. McLELLAN, M.P., Secretary

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1
2 ---On resuming at 10:30 a.m.

3
4 THE CHAIRMAN: Gentlemen, I see that we
5 have a quorum. The meeting will come to order.

6 We all regret, of course, that our
7 Chairman is unable to be with us today, and some of the
8 members of the Committee had other duties that required
9 them to be away.

10 However, we do appreciate that Mr. Antoft,
11 President of Nordic Biochemicals Limited, Montreal,
12 has agreed to supply us with information, and I would
13 like to ask Mr. Rice, who has been talking to Mr.
14 Antoft for a little while, to introduce Mr. Antoft to
15 the Committee.

16 MR. RICE: Mr. Chairman, and members of
17 the Committee, the witness we are to hear from this
18 morning, as the Chairman has indicated, is Mr. Antoft
19 from Nordic Biochemicals Limited, Montreal.

20 Mr. Antoft, for the purpose of the
21 record, would you state your full name?

22 MR. ANTOST: Karl Antoft.

23 MR. RICE: And where do you reside?

24 MR. ANTOST: I live in Beau Repaire,
25 which is a suburb of Montreal.

26 MR. RICE: How long have you been
27 president of Nordic Biochemicals Limited?

28 MR. ANTOST: Since its incorporation in
29 1951.

30 MR. RICE: What did you do prior to that

---On resuming at 10:30 a.m.

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have a program. The meeting will come to order.

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MR. ANTORT: I live in Beau Repaire,

which is a suburb of Montreal.

MR. RICE: How long have you been

President of Nordic Biochemicals Limited?

MR. ANTORT: Since its incorporation in

1951.

MR. RICE: What did you do prior to that



1
2 time?

3 MR. ANTOFT: Before that time I was the
4 president of Viking of Air Service.

5 MR. RICE: What type of work did that
6 business do?

7 MR. ANTOFT: We were a sales agency for
8 aircraft and aircraft spare parts. We were exporting
9 aircraft spare parts from Canada to Europe and England.

10 MR. RICE: Where did you carry on that
11 business?

12 MR. ANTOFT: Also in Montreal.

13 MR. RICE: Have you any formal education?

14 MR. ANTOFT: Yes. I studied at Dalhousie
15 University in the Department of Public Administration.
16 I reached a third-year standard before I joined the
17 Air Force in 1943.

18 MR. RICE: What was that course again?

19 MR. ANTOFT: It was a course in public
20 administration.

21 MR. RICE: What did you do in the Air
22 Force?

23 MR. ANTOFT: I was a navigator.

24 MR. RICE: How long have you been attached
25 to the drug industry? Just since 1953?

26 MR. ANTOFT: Since 1951.

27 MR. RICE: I understand you have a prepared
28 brief or statement that you would like to present
29 to the Committee.

30 MR. ANTOFT: Yes, that is correct.



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1
2 MR. RICE: Would you proceed, please.

3 SUBMISSION OF
4 K. ANTOFT, President,
5 NORDIC BIOCHEMICALS LIMITED
6

7 APPEARANCE: K. Antoft, President, Nordic Biochemicals
8 Limited.

9 Nordic Biochemicals Limited is a
10 Canadian corporation, incorporated under the laws of
11 the Dominion of Canada. All of the members of the
12 Board of Directors are Canadian citizens and all the
13 shares of the corporation are owned by Canadian citizens.

14 The Company was organized in 1951 and
15 since that time has engaged in the manufacture, packaging,
16 and distribution of pharmaceutical products. The
17 Company operates solely in the field of "ethical" drugs,
18 in that its products are promoted solely to the medical
19 profession and are not advertised to the general
20 public.

21 The sales of the Company during the year
22 1960 did not exceed \$250,000.00.

23 With this brief background, we should
24 like to describe some of the activities of our Company,
25 in order to correct the impression that only the
26 larger, usually non-Canadian firms, are able to
27 develop and market products that are original or
28 complex.

29 We expect to show that size does not
30 dictate originality, the amount of research carried on,



MR. RICE: Would you proceed, please.

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2 the ability to develop new drugs and important
3 specialties and to market such successfully.

4 When we have established that we are not
5 merely imitators, the Committee may find that our
6 remarks on price factors will carry more weight.

7 A. MANUFACTURING HISTORY:

8 Our Company was originally established to
9 commence the manufacture of Corticotropin, or more
10 commonly known as ACTH, in Canada. In 1951, there
11 was a great scarcity of this important new and complex
12 therapeutic agent, as existing methods of extraction
13 and purification were primitive and inefficient. This
14 supply situation and the importance of ACTH was
15 recognized by the Canadian government, who through the
16 National Research Council, financed Connaught Research
17 Laboratories in Toronto to set up an ACTH manufacture
18 during this period.

19 Our Company, in collaboration with a
20 group of Scandinavian drug manufacturers were rapidly
21 able to solve the main problems of the extraction
22 procedure, enabling us to increase the ACTH yield some
23 eight-fold over the previously used methods. At the
24 same time, the new process yielded the much superior
25 Corticotropin, type A, which is of much higher purity
26 than previous preparations. We claim no credit for
27 this original extraction procedure, (which was developed
28 by Dr. E. B. Astwood and his associates in Boston), but
29 it was through our work in Montreal that what had
30 hitherto been an intricate laboratory method became



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2 suitable for large-scale processing. As a consequence,
3 a product having approximately 20 times the potency
4 and purity of the International Standard became
5 available to Canadian physicians even before such a
6 product was available in the United States. The greater
7 yields also led to rapidly declining costs of the
8 finished product.

9 In 1953, our Company pioneered in the
10 development of a long-acting form of ACTH. As the native
11 hormone is relatively short-acting, therapy formerly
12 required multiple daily injections. Several repository
13 forms of the drug manufactured in the United States
14 had made their appearance on the Canadian market, but
15 all had serious drawbacks. By utilizing an entirely
16 different principle, we were able to make a Canadian
17 preparation which was both more convenient and longer
18 acting. The pharmacological and clinical testing of
19 this new preparation was carried out initially in
20 Montreal and clinical results were reported in the
21 Journal of the Canadian Medical Association, (Rose,
22 Bram, "Long-Acting Corticotrophin in Allergic Disease",
23 I must apologize that this paper is not appended through
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25 to the secretary. The importance of this Canadian
26 development may best be emphasized by quoting from the
27 Wayne University Handbook* on ACTH. In *"CORTICOTROPHIN:
28 Its pharmacologic effects in man and practical
29 therapeutic utilization. (Detroit 1955)"., discussing
30 ACTH preparations available in the United States, a



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2 statement appears on page 4: "For Canadian physicians,
3 however, the superior duration of action of
4 carboxymethylcellulose Corticotrophin offsets this
5 defect. Unfortunately, this material is not available
6 in the U.S.A. at the time of writing....." As
7 a footnote, I may say that we are just in the process
8 of organizing an American subsidiary, reversing the
9 usual trend of where American companies set up Canadian
10 subsidiaries.

11 It should be noted that we do not merely
12 purchase such drugs for resale, but that the manufacture
13 of Corticotrophin is carried out completely in our own
14 plant in Montreal, utilizing the pituitary glands of
15 hogs slaughtered in Canadian packing plants.

16 During our existence, we have developed
17 and placed on the market other new specialties that
18 are neither trivial in concept nor copies of products
19 developed by other, larger firms. For example, some
20 years ago, we found a practical method of getting
21 hydrocortisone into solution. This principle has
22 resulted in a line of topical hydrocortisone
23 preparations that are widely used because of their
24 enhanced effectiveness and lower cost.

25 RESEARCH HISTORY:

26 A review of our research activities
27 during the past ten years will demonstrate that we have
28 been alive to our responsibilities in Canadian medical
29 development. It must be recognized, of course, that
30 only a small part of any research which is carried out



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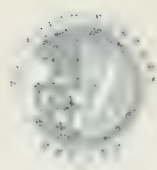
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only a small part of any research which is carried out



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2 results in commercial products, but the policy we follow
3 is to permit as much scope as possible to our technical
4 personnel in developing their ideas, improving their
5 professional techniques, and in encouraging original
6 and creative thinking. It is a fallacy to assume that
7 productive research can only be carried out through
8 the much publicized "crash programs", involving armies
9 of technicians and batteries of complex gadgets and
10 computers. On the contrary, it needs hardly be pointed
11 out that many of man's most fruitful discoveries have
12 been made by individuals whose thinking was sharpened
13 by the need to improvise and "make do" with a minimum
14 of resources. In the field of fundamental research,
15 commercial size in itself may often be a handicap.
16 The need to seek approval for each step from management
17 committees is likely to lead to stagnation in this
18 area.

19 It has been the aim of our company to
20 allow our personnel the greatest possible latitude in
21 designing and carrying out original research, supporting
22 them as much as our limited resources permits. As
23 a result, our Company is well known in North American
24 medical research centres as a source of several
25 research materials, and also as a place to which
26 investigators may turn for aid in developing techniques
27 or in translating laboratory procedures into pro-
28 duction methods. A review of projects that we have
29 undertaken or have participated in would demonstrate
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that the commercial motive is secondary in most of undertaken or have participated in would demonstrate
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or in translating laboratory procedures into pro-
investigators may turn for aid in developing techniques
research materials, and also as a place to which
medical research centres as a source of several
a result, our Company is well known in North American
them as much as our limited resources permits. As
designing and carrying out original research, supporting
allow our personnel the greatest possible latitude in
It has been the aim of our company to
committees is likely to lead to stagnation in this
The need to seek approval for each step from management
commercial rise in itself may affect a number of
of resources. In the field of fundamental research,
by the need to improvise and "make do" with a minimum
been made by individuals whose thinking was sharpened
out that many of man's most fruitful discoveries have
computers. On the contrary, it needs hardly be pointed
of technicians and batteries of complex gadgets and
the much publicized "crash programs", involving armies
productive research can only be carried out through
and creative thinking. It is a fallacy to assume that
professional techniques, and in encouraging original
personnel in developing their ideas, improving their
is to permit as much scope as possible to our technical
results in commercial products, but the policy we follow



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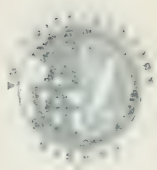


/dpw

Our Company has undertaken the extraction of various glandular tissues, for the purpose of assisting investigators exploring the physiology and biochemistry of the human body. We have made extracts of pineal glands, diencephalon, the thymus gland, blood, and other tissues, and have made these extracts available without charge to a large number of people working in various Canadian research centres.

Human Growth Hormone Project

Since the existence of pituitary growth hormone was first demonstrated early in the 1940's, many trials had been made with a view to reproducing in man the effects observed in animals from the administration of this hormone. Although many investigators were involved in this research work, the hormone made from animal sources remained without effect when given to man. In 1958, a group of investigators at Harvard University demonstrated that the hormone extracted from monkey pituitaries had a significant effect when injected back into the same species. After this was reported, Dr. John Beck, of the University Clinic at the Royal Victoria Hospital in Montreal, asked us to set up a collection of monkey pituitaries from animals being used in the Salk vaccine program. Although we secured the complete cooperation of the University of Montreal's poliomyelitis vaccine laboratory, the collection of these pituitaries proved to be very cumbersome. It soon became apparent that it would take several years to collect sufficient monkey pituitaries to make single



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1
2 extraction worthwhile. Therefore, we began to collect
3 human pituitaries from autopsy cases, in order to test
4 the theory that growth hormone was species specific in
5 man. I have added a footnote: The credit for this ori-
6 ginal idea actually belongs to one of our detail men,
7 or salesmen, Mr. William Levain, who also was active in
8 making arrangements with Pathology Departments throughout
9 Montreal.

10 As a result, Dr. Beck became the first
11 clinician to use human growth hormone in a human patient,
12 and he demonstrated that its activity paralleled the
13 results expected from animal experiments. His work has
14 set off a wave of interest in this field, and while the
15 collection of human pituitaries has now become standard
16 practice throughout the world, the initial idea remains
17 a Canadian one. Our Company continues to collect pitui-
18 taries from pathologists at the major hospitals through-
19 out Canada, extracting the human growth hormone from
20 these. Due to its extreme shortage, the available
21 supply is allocated through the Canadian Society for
22 Clinical Investigation, and we administer this program
23 solely at our own expense. It is of course obvious
24 that until another source of starting material is found,
25 this project is purely a research undertaking which is
26 unlikely to have any commercial significance.

27 Miscellaneous pituitary hormone fractions

28 With the great interest in pituitary
29 physiology, there is a constant demand for various
30 pituitary hormones, as well as for fractions that have



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Discussion of the Growth Hormone Problem

With the great interest in pituitary physiology, there is a constant demand for various pituitary hormones, as well as for fractions that have



1 not yet been identified as hormones. We offer a nearly
2 complete range of all the known pituitary hormones. In
3 addition, we continually make various fractions whose
4 hormonal action has not yet been characterized. In
5 some instances, we have supplied starting material from
6 which research workers carry out further fractionation.
7 As examples, two of the substances that are currently of
8 interest to us are the "fat mobilizing" factor from the
9 pituitary, and the factor in the pineal gland area which
10 appears to regulate fluid retention.
11

12 In most cases we supply these research
13 preparations without charge. If we do not make a parti-
14 cular pituitary hormone ourselves, we may purchase the
15 fraction from one of the members of our Scandinavian
16 research pool. These are imported by us at our own
17 cost and distributed, in most cases, without charge to
18 the interested research group.

19 PROMOTIONAL METHODS

20 While we are very loath to spend our
21 limited resources for non-productive promotional pur-
22 poses, our Company has not hesitated to undertake useful
23 and original promotional and educational campaigns. As
24 an example, we may point to the symposium on ACTH which
25 we sponsored jointly with the Hopital St. Francois
26 D'Assise in Quebec City, in 1955. We had become aware
27 at that time that the French language medical literature
28 on ACTH was relatively incomplete, compared to the
29 information available in English. Therefore, we
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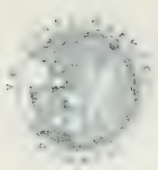
1 French-speaking doctors in the Quebec City area.
2
3 Specialists in the field of rheumatology, pediatrics,
4 allergy and endocrinology were brought from Toronto
5 and Montreal to present the latest and most authoritative
6 clinical experience to general practitioners in the
7 area. These proceedings were subsequently published in
8 the medical journal of Laval University, "Laval Medical",
9 and were distributed in booklet form to the French-
10 speaking members of the Canadian medical profession.
11 Although the expense of this conference and the later
12 publication were perhaps out of proportion to the size
13 of our Company, we have enjoyed lasting benefit from the
14 good will engendered by this conference.

15 As a result of following such policies,
16 our reputation with the Canadian medical profession is
17 certainly as high as that of any other ethical drug
18 house, regardless of size. Indeed, there are several
19 of the large organizations whose reputation for high-
20 power promotion and colourful product claims arouse no
21 feelings of envy in us.

22 We should now like to turn our attention
23 to various factors that influence drug prices in Canada.

24 EFFECTS OF TARIFFS AND SALES TAX

25 I mention as a footnote that the main
26 body of this brief was originally prepared for the
27 Dominion - the Government of Canada Restrictive Trade
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2 Although tariffs may have a tendency to
3 raise prices, there is evidence that the existing tariffs
4 and dumping duties do have a beneficial influence on
5 the Canadian drug industry. Thus, our Company is
6 engaged in the sterile filling of the antibiotic products
7 of a major American manufacturer who does maintain
8 Canadian facilities for filling injectables himself.
9 By exporting bulk materials rather than a finished
10 product, he is entitled to send the material into Canada
11 at a low import price, thus effecting a saving in duty
12 and also eliminating the possibility of having to pay
13 dumping duty on an assigned "fair market value" on the
14 finished product. In this case, the effect on prices
15 is downward, and the dumping duty regulations probably
16 have a tendency to lower the cost of these products,
17 while at the same time giving employment to Canadian
18 manufacturing personnel.

19 With regard to sales tax, however, the
20 Canadian manufacturer is in an unfair position in
21 comparison to foreign companies exporting into Canada.
22 As most hospitals buy on a sales tax exempt basis, the
23 collection of sales tax does not enter into such prices.
24 However, many of the materials used in a Canadian
25 manufacturing plant are not eligible for sales tax
26 exemption, even though the end-product may be entirely
27 sales tax exempt, as is the case with ACTH. The
28 American manufacturer, however, who sells sales tax
29 exempt goods in Canada is not subject to payment of
30 Canadian sales tax as any part of his manufacturing cost.



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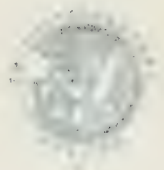


1
2 As an example of how this may operate to
3 the disadvantage of the Canadian manufacturer, we wish
4 to cite a recent specific ruling by the Department of
5 National Revenue in our own case:

6 While all the injectables we manufacture
7 are either specifically exempt from sales tax or
8 usually become so by virtue of their sale to hospitals,
9 it was recently ruled that sterile masks, which are used
10 in sterile filling operations, could not be considered
11 as entering into the process of manufacture directly.
12 Therefore, we are assessed sales tax on these masks.
13 To the extent of this tax, our production cost is
14 increased.

15 An American manufacturer, however, dealing
16 in the same type of injectables, which are likewise
17 sales tax exempt, would not be subject to payment of
18 sales tax on the cost of these masks in his factory.
19 To this extent, he receives preferred treatment by
20 carrying on his manufacturing operations outside of
21 Canada. Although masks are of course a minor cost
22 item, it is only one of a large class of laboratory
23 supplies that do not qualify for tax-free purchase.

24
25
26 -
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As an example of how this may operate to

the disadvantage of the Canadian manufacturer, we wish

to cite a recent specific ruling by the Department of

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are either specifically exempt from sales tax or

usually become so by virtue of their sale to hospitals,

it was recently ruled that sterile masks, which are used

in sterile filling operations, could not be considered

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To the extent of this tax, our production cost is

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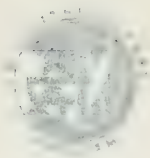
Ownership of pharmaceutical manufacturing houses

It must be admitted that the non-Canadian drug manufacturers have in large measure contributed to the rich store of valuable therapeutic weapons that the Canadian medical profession has at its disposal. Because it is controlled from outside of Canada, marketing practices and pricing are factors that fall largely beyond the control of Canadian market pressures or governmental control. In the main, purely Canadian influences on prices are usually in an upward direction, due to the tariff and sales tax which is added to the imported goods.

It appears that there is some awareness that manufacturing costs of most drugs marketed in Canada are not easily subject to scrutiny by Canadian authorities. Therefore, since any possible abuses largely originated outside of Canada, it would perhaps be unfair to call the few solely Canadian companies to account for those sins of whose fruits they only enjoy an insignificant fraction. It would perhaps be more useful to consider methods of encouraging the development of a native pharmaceutical industry whose behaviour would be solely dictated by Canadian conscience and Canadian law. We will have specific recommendations in this field in a later part of this brief.

The role of the retail druggist in Canada

Much has been made in the popular press, particularly as a result of the so-called "Kefauver Committee" in the United States, of the differences in



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2 cost of retail drugs in North America as compared to
3 various European countries, and the same subject is
4 raised in the "Material". This is a reference made
5 available to us from the Trade Practices Commission
6 enquiry in Ottawa. The organization of European drug
7 distribution differs greatly from that in North America
8 and these differences are necessarily reflected in the
9 price that the consumer pays for the retail package.

10 In many European countries, the retail
11 pharmacist does not operate as a free competitive agent.
12 In Denmark, as one example, with which I am familiar,
13 the owner of a pharmacy derives his authority to operate
14 his drug store by Royal resolution, the number of phar-
15 macies is limited by law, locations are rigidly
16 controlled by the Home Ministry, and prescription
17 pricing is determined by the official schedules laid
18 down published by governmental authorities.

19 This rigid framework has led to Danish
20 pharmacies developing in a completely different direc-
21 tion that that commonly seen in North America. Thus,
22 in all of Denmark there is one pharmacy for every
23 13,000 persons, while in Copenhagen the ratio is about
24 1 to each 16,000 of population. This is in contrast
25 with the Canadian average of only 3,624 persons per
26 pharmacy reported in 1960 (see page 66 of the "Material").
27 The Danish pharmacies are, in fact, small pharmaceutical
28 factories, equipped to carry out their own tableting,
29 filling of injectables, ointment preparation etc., but
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1 and such sources of income as soda fountains and
2 department-store merchandise are not permitted.
3

4 The net effect of controlled prices and
5 local manufacture is that the retail mark-up is much
6 lower than in Canada. It is interesting to note that
7 in 1958, a total volume of 20.6 million prescriptions
8 were filled by Danish pharmacies for a total cost of
9 \$19,500,000. Thus, the average cost of a prescription
10 was less than \$1.00, while in Canada the figure in the
11 same year was \$2.78.

12 This information is entered in our brief
13 not with a suggestion that this system is preferable
14 to the one that prevails in Canada, but purely to point
15 out that in comparing prices in different countries,
16 many factors beyond the avarice of individuals or
17 corporations may enter into the picture.

18 It is quite apparent that the Canadian
19 pharmacist is faced with a very thorny dilemma. He is
20 rapidly losing his professional standing, as the trend
21 to pre-packaged drugs calls upon less and less skill
22 in dispensing. It is noticeable in all Canadian drug
23 stores that the facilities required for compounding
24 are rapidly diminishing. The serious pharmacist who
25 is interested in his profession often leaves the
26 retail field and enters industry, hospitals, or govern-
27 ment bodies, where he can exercise more of his academic
28 qualifications. The result is that retail drug stores
29 are becoming more the domain of merchandisers, whose
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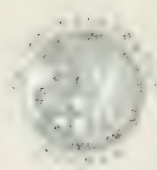
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2 promotional and merchandising techniques rather than
3 by their specific knowledge of pharmacy.

4 Although the Canadian Pharmaceutical
5 Association is highly disturbed at the loss of
6 professional prestige which they feel their members
7 have suffered in the eyes of the public, they apparently
8 do not appreciate fully that this is the price that
9 they must pay for becoming successful merchants. Perhaps
10 the Canadian Pharmaceutical Association is itself
11 contributing towards emphasizing the role of the druggist
12 as a business man. Any issue of the Canadian Pharma-
13 ceutical Journal shows that preoccupation with the
14 purely commercial side of the profession receives a
15 large measure of editorial attention, and certainly is
16 the theme of practically all the advertisements
17 directed at the practising pharmacist. As an example,
18 the March 1961 copy of this publication contains 21
19 full pages of advertising. Most of these advertisements
20 are by drug manufacturers. Those that deal with
21 specific products emphasize the profit advantage in
22 "pushing" the product concerned. The phraseology is
23 illustrative of this and the following are examples,
24 each culled from a separate advertisement in this issue:
25 "High margin medication" - "You profit from rapid
26 turnover and repeat business" - "New profits to you" -
27 "Another profit producer" - "Traffic builders for you" -
28 "Another potential best seller" - "Recommend them for
29 increased profit" - "Cash in on these.....deals" -
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1 whole tone of advertising directed at the retail pharma-
2 cist is well summarised on the back cover ad of this
3 issue: a list of the advertiser's products are set
4 forth in an attractive box whose border is formed of
5 \$\$\$\$ signs!

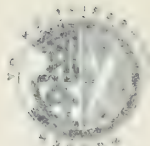
6
7 MR. BRYDEN: Is there any particular
8 reason why you chose the March 1961 issue? Did this
9 just happen to be the latest?

10 MR. ANTOFT: It happened to be the time
11 I was preparing this brief. I am sure that any other
12 issue would ---

13 MR. BRYDEN: Show the same.

14 MR. ANTOFT: --- show exactly the same
15 picture.

16 The druggist who is striving for profes-
17 sional stature would do well to compare the advertise-
18 ments to which he is exposed in his own trade journals
19 with those that the same drug manufacturers place in
20 the journals directed at the medical profession. In
21 the latter, advertisements suggesting that the reader
22 will derive material profit from prescribing a specific
23 product is, of course, unheard of, and every pharma-
24 ceutical manufacturer knows that such ads would be
25 rejected out of hand by the editorial board of every
26 medical journal. It is obvious that the profession of
27 pharmacy will never achieve its desired stature unless
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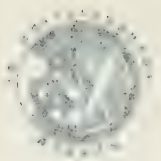
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2 RETAIL PRICING

3 A large part of the resentment in the
4 public mind about drug prices results from the variation
5 in the price of an identical prescription, from one
6 drug store to another. Retail druggists have wrestled
7 with this problem of pricing for many years and
8 numerous formulae have been suggested to achieve unifor-
9 mity. The predominant thought is that the price of a
10 prescription should reflect not only the cost of the
11 ingredients, but also the "professional fee" of the
12 druggist filling the prescription, and varying amounts
13 and percentages are therefore added. For this reason,
14 the manufacturer has only a very partial influence on
15 the ultimate cost of his product to the patient. In
16 our own case, we set a list price on each of our
17 products, and on this list price, we grant a 40% discount
18 on direct sales to hospitals, pharmacists and doctors,
19 (with additional discounts to wholesalers and distribu-
20 tors). In various ways, however, we become aware that
21 our products are often sold to the consumer at prices
22 well above these "list prices". A recent example
23 occurred when a package was returned to us for credit.
24 In ink, it carried a price notation "3.75". As the
25 list price on this product is \$1.40, the druggist
26 would have paid us \$0.84 if he had bought it from us
27 directly. (As it happens, we were able to identify
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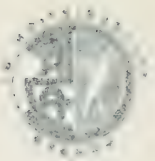


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2 As a manufacturer, we are naturally
3 concerned with retail pricing policies by the drug
4 stores, as the excessive "loading" of a retail price
5 will work to diminish our market. Furthermore, such
6 practices will tend to further impair the consumer's
7 view of the manufacturing industry, as the blame for
8 high prices of drugs is usually attributed to the greed
9 of the manufacturer.

10 It is difficult to envisage any legisla-
11 tive action which would contribute to a solution of
12 this problem. However, we feel strongly that the
13 druggist, if he feels he is entitled to a professional
14 fee, should list this fee as a separate item on his
15 prescription bill to the patient. In this way, he
16 would emphasize his professional function and the
17 question of his fees would be divorced entirely from
18 the discussion of high drug costs.

19 MANUFACTURER'S PRICING POLICIES

20 When Nordic Biochemicals Limited was
21 established in 1951, we approached our responsibilities
22 with what appears in retrospect to be naive idealism.
23 We assumed that all that was necessary to thrive and
24 expand in the Canadian drug manufacturing industry was
25 to offer the best possible product at a reasonable
26 price, in the expectation that within a very short time
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ANGUS. STONEHOUSE & CO. LTD.
TORONTO. ONTARIO

Antoft

1877

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2 direct mail promotion, an army of detail men, or huge
3 sampling programs were envisaged. While this philosophy
4 was operative, the company teetered on the brink of
5 disaster, but only with reluctance and by degrees did
6 we accept the "facts of life", and the company finally
7 began to prosper.



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It was rapidly discovered that although doctors publicly deplore the mass of direct mail literature, a sales volume on practically any product could be created by advertising it by mail providing it is done persistently and massively. Detail men are an expensive method of securing sales, but without them, cobwebs grown on the order desk. Thirdly, in order to detail, a representative must usually "bribe" his way into the doctor's presence by the offer of free samples in generous volume. The drug house who neglects any of these three sales methods invites its own decline. At the same time, the flamboyant overuse of such sales methods has led to increasing coolness between responsible sections of the medical profession and the pharmaceutical industry as a whole. As a consequence, the channels of communication between the doctor and the drug manufacturer deteriorate, and the cost of drug promotion increases. More and more mail is needed to put across a given idea, more and more time is wasted by detail men in attempting to see doctors who are determined to see as few of these salesmen as possible, and more and more samples are shoveled out in an attempt to catch the eye of the men who write prescriptions.

Although Nordic Biochemicals has been forced to adopt some of this sales pattern, we have attempted to maintain a sense of proportion in doing so. Our direct mail is designed to be informative rather than persuasive. Our detail men are required



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to be experts in our own particular field, so that their advice may be followed with confidence. As much as possible, we attempt to channel whatever sampling we are required to do into avenues where indigent patients will benefit.

Currently, these three avenues of sales promotion, plus a very limited journal advertising, costs us approximately 35% of our gross sales. While we would much rather spend this money on research and development or on reducing our prices, we know from experience that without these sales expenditures, there will be no sales.

While sales promotion is the largest single factor reflected in our price structure, it should also be noted that we do operate in a field where the cost of raw materials is very high. In the manufacture of ACTH, our starting raw product is the pituitary gland of the hog. These currently cost us \$700.00 per kg. in the dried state, when bought from the slaughter houses. This represents the pituitaries from approximately 30,000 hogs. In the actual extraction, there is a great element of risk, as the yields may vary from 50,000 I.U. per kg. of glands, up to 140,000 I.U. The cost of assaying ACTH is also very considerable, in that an assay of a Master Lot may require up to 150 rats, each one of which must have its pituitary removed by a very intricate operation.

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4 SUMMARY AND RECOMMENDATIONS:

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6 impression that new ideas are the prerogative of the
7 larger, usually foreign-based pharmaceutical manu-
8 facturers. We have attempted to point out some of
9 the factors that not only operate to determine drug
10 prices, but that also influence the public's opinion
11 of drug prices. We have stressed the high cost
12 of communicating with the doctor and have pointed out
13 that this cost is likely to increase unless more
14 rational and direct communication is established
15 between the drug manufacturers and the doctors.

16 Relations between the pharmaceutical
17 industry, the retail druggists, and the medical
18 profession, should be studied by the three groups, and
19 we feel that there is little that can be accomplished
20 in this area by any governmental action.

21 A question of whether or not additional
22 regulation or legislation is necessary to modify drug
23 prices will remain largely academic while the major
24 part of Canada's drug needs are supplied by parent
25 sources beyond the jurisdiction of Canadian laws and
26 market influences.

27 It is submitted that a more rational
28 approach to the problem is to develop means of
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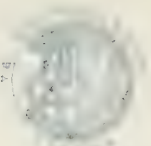
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3 is important that such operations should be allowed
4 to operate with as much commercial independence of the
5 parent company as possible. When a Canadian subsidiary
6 is purely a branch office or a branch factory with all
7 policies decided in a head office located outside of
8 Canada, such organizations are vulnerable to decisions
9 that may not be in Canada's national economic interest.
10 Thus, the recent closing of one of the major basic
11 manufacturers in the pharmaceutical industry in Canada
12 turned out to be disastrous for several hundred people
13 who were dependent on this plant for their livelihood.
14 While it may be good policy to close down a branch
15 factory in times of contracting sales, one may speculate
16 if an independent Canadian company in a similar
17 circumstance would not have had great incentive to
18 rationalize and diversify its production, rather than
19 shut down completely.

20 To encourage the growth of the Canadian
21 pharmaceutical industry would increase competition
22 with the resulting prospect of lowering prices. The
23 only basis for any sound industry, however, is in the
24 development of new ideas and new products. This
25 requires that existing Canadian industries devote
26 more of their resources towards both basic and applied
27 research.

28 On the part of government, such objectives
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7 mising results have already developed from this
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9 Many of the medical research programs
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11 well be broadened to enlist the cooperation of
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13 incentive would be given to scientists to enter Canadian
14 industry and thus enlarge the horizon of Canadian
15 manufacturers. Our position is weak in competing in
16 mass production, but this deficiency could certainly
17 be overcome by employing more inventive genius.

18 MR. RICE: Mr. Antoft, could you give
19 us some more information about your company, is it a
20 member of the Canadian Pharmaceutical Manufacturers'
21 Association?

22 MR. ANTOfT: No sir.

23 MR. RICE: What would be the value of
24 the investment in equipment and stock of your company?

25 MR. ANTOfT: A total investment, both
26 in stock and working capital and equipment and so on, is
27 approximately \$70,000.00. Of this, about \$35,000.00
28 to \$40,000.00 is in plant and equipment. We do not
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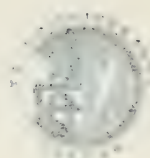
5 MR. ANTOFT: Originally we were formed
6 as a result of an agreement between a Danish company
7 and myself. At that time the great bottleneck in ACTH
8 production was the source of supply of pituitary glands.
9 They are very difficult to remove from the animal,
10 and the Danish company had developed a very neat gadget,
11 which was a bone drill to be used in slaughter houses,
12 that went through the back of the neck of the animal
13 and extracted the pituitary, so it became possible to
14 start collecting pituitaries from smaller slaughter
15 houses, who up to that time were not equipped to split
16 the heads of the animals and get out the pituitaries.

17 The Danish representative of the company,
18 through one of my childhood friends, approached me to
19 see if I could organize the collection of pituitaries
20 in Canada. At that particular point I was looking
21 around for a new field of endeavour, as the aviation
22 industry was developing in a direction which didn't
23 seem to offer too much future as far as we were
24 concerned.

25 An agreement was made whereby I agreed
26 to put up 50% of the required capital, and the Danish
27 company agreed to put up 50%, and we estimated we would
28 need \$40,000.00 approximately to start with.

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Due to currency restrictions, and so on, the Danish company were not able to put up their half, and I was called upon to scrape the money elsewhere. The initial investments on my side, and my brother who was associated with us, was in the neighbourhood of \$25,000.00.

MR. RICE: The total investment was originally \$25,000.00.

MR. ANTIFT: Yes. Later on we had additional capital.

MR. RICE: You expanded from that to \$70,000.00 today?

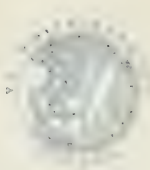
MR. ANTIFT: Yes.

MR. WHITE: Except, Mr. Rice, that may not be the net worth. Is it fair to ask what your net worth is today?

MR. ANTIFT: Well, this is quite a fair question. I don't have the figures readily available for me, but we have for some years been operating very close to the line, and the only profit, sizeable profit we have made is when we bought a piece of land and put a plant on. We have an operating surplus which is entirely accounted for by this windfall of some \$18,000.00, and this is in addition to the paid up capital and the loans where the company makes up the \$70,000.00.

MR. WHITE: When you say an operating surplus, is that taking into consideration depreciation?

MR. ANTIFT: That is our actual surplus.



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2 MR. RICE: How many products do you
3 manufacture?

4 MR. ANTOfT: We list about 15 products
5 in our price list. Some of these are different
6 formulations of the same basic idea.

7 MR. RICE: Have you any copy of your
8 price list you could file with the Committee?

9 MR. ANTOfT: Yes, I would be glad to do
10 so.

11 MR. RICE: And do you manufacture these
12 products under the generic name or under a trade or
13 a brand name?

14 MR. ANTOfT: In most cases we have a
15 brand name for them. The obvious difficulty of a
16 doctor trying to find a long-acting ACTH he would have
17 to write it up with carboxymethylcellulose.

18 MR. RICE: And you have told us something
19 of your manufacturing procedure with regard to ACTH.
20 Could you tell us something about the other products
21 that you manufacture? Is it as extensive as ACTH?

22 MR. ANTOfT: No. ACTH is a product that
23 we manufacture from a raw material. In the case of
24 most of the other products we start with bulk chemicals,
25 and our function is mainly that of formulating and
26 packaging.

27 MR. RICE: Where would you get these
28 bulk chemicals from for these products?

29 MR. ANTOfT: The main ingredient or the
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2 and we buy the hydro cortisone from various sources,
3 from Europe.

4 MR. RICE: Could you tell us the sources?

5 MR. ANTOFT: We purchase from our
6 associate company in Sweden, who in turn purchase from
7 a French company. We have a pool where we can get
8 quantity prices on them.

9 MR. WHITE: What is your brand name?

10 MR. ANTOFT: Cortinent. The bulk of our
11 sales is ACTH, with the hydro cortisone preparation
12 coming next. We distribute one product which we do
13 not manufacture ourselves, a trypsin preparation which
14 we import from a Danish company and distribute under
15 their label. The intention is that when the volume
16 becomes large enough to do some of the manufacturing
17 here, this will be the procedure carried on.

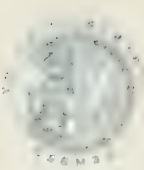
18 MR. RICE: The major part of your purchases
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20 MR. ANTOFT: Yes. Hydro cortisone, this
21 is from Sweden.

22 MR. RICE: Do you purchase from other
23 companies too?

24 MR. ANTOFT: We purchase from Denmark
25 and, of course, our bulk chemicals for the processing
26 of ACTH, for the formulation of hydro cortisone
27 preparations, these are all purchased in Canada, from
28 local suppliers.

29 MR. RICE: Do you do any purchasing in
30 the United States?



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2 MR. ANTOFT: Not directly. Many of these
3 bulk chemicals and solvents do originate in the United
4 States, but we buy locally.

5 MR. RICE: I notice you say in your brief
6 that your total sales in 1960 did not exceed \$250,000.00.
7 Can you tell us what your total sales were in 1960?

8 MR. ANTOFT: About \$220,000.00. The
9 figure was given to establish us not as one of the
10 major plants.

11 MR. RICE: Could you tell us where you
12 sold these products? Did you sell them in Canada or
13 Europe?

14 MR. ANTOFT: The products we sell are
15 sold entirely in Canada.

16 MR. RICE: And in one province?

17 MR. ANTOFT: We have a pretty uniform
18 distribution. We maintain our own sales force in the
19 Province of Ontario, Quebec, and in Western Canada we
20 distribute through a distributor, a surgical supply
21 house, a salesman selling for us. With one exception,
22 we have sent a man to British Columbia to assist the
23 distributor.

24 MR. RICE: Can you give us any percentage
25 of sales sold in Ontario?

26 MR. ANTOFT: I would say that, very
27 roughly, about 25% to 28%.

28 MR. RICE: You have told us that the
29 quality control, on page 16 of your brief, accounted
30 for about 9% of sales. Could you explain what quality

for about 2% of sales. Could you explain what quality
quality control, on page 16 of your brief, accounted

MR. RICE: You have told us that the

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MR. ANTOFT: I would say that, very

of sales sold in Ontario?

MR. RICE: Can you give us any percentage

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Can you tell us what your total sales were in 1950?

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MR. RICE: I notice you say in your brief

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bulk chemicals and solvents do originate in the United

MR. ANTOFT: Not directly. Many of these



1 control you have at your plant?

2 MR. ANTIFT: Yes. We have a laboratory
3 of just nothing else but quality control. We have a
4 bacteriologist who holds a degree, Master of Science,
5 McMaster University, biology, and who has as an assistant
6 a laboratory technician. These people do quality
7 control exclusively, and they work in their spare time
8 in research. Of course, apart from these two people,
9 production control expenses, and so on, account for
10 an additional cost in this field.
11

12 MR. RICE: You have also explained in
13 your brief a fairly extensive research and development
14 programme. Would you tell us what percentage of your
15 sales go to satisfy the expenses involved there?

16 MR. ANTIFT: As you have noticed in this
17 brief, I have lumped the research and quality control
18 in the one figure. I should point out that in an
19 organization such as ours, whenever we have a research
20 project we may have production personnel who are doing
21 some of the work, carried out on a part-time basis. It
22 is very hard to separate how one person has spent their
23 day, whether they have spent two hours working on the
24 one project and six hours on something else. The figure
25 of 9% are the costs that we can directly attribute
26 mostly to the maintenance of the quality control
27 laboratory where there are two people who do not enter
28 into production whatsoever.

29 MR. RICE: Can you give us any estimate
30 as to how much, what percentage of your gross sales would



control you have at your plant?

of just nothing else but quality control. We have a bacteriologist who holds a degree, Master of Science, McMaster University, biology, and who has an assistant a laboratory technician. These people do quality control exclusively, and they work in their spare time in research. Of course, apart from these two people, production control expenses, and so on, account for an additional cost in this field.

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organization such as ours, whenever we have a research project we may have production personnel who are doing some of the work, carried out on a part-time basis. It is very hard to separate how one person has spent their day, whether they have spent two hours working on the one project and six hours on something else. The figure of 2% are the costs that we can directly attribute

mostly to the maintenance of the quality control

laboratory where there are two people who do not enter

MR. RICE: Can you give us any estimate

as to how much, what percentage of your gross sales would



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be required for raw materials?

MR. ANTOFT: Well, I can give you the actual figure of what we purchase in the way of pituitary glands. We usually buy from \$25,000.00 to \$30,000.00 worth of pituitary glands per year. And then, of course, this is for the ACTH production programme.

MR. RICE: In all your programmes, what amount of the \$220,000.00 would be required to purchase raw materials in your business?

MR. ANTOFT: I would estimate approximately 20% 25%.

MR. RICE: Could you tell us approximately what percentage of the \$220,000.00 sales would be gross profit?

MR. ANTOFT: Yes. Gross profit is approximately 45% of our gross sales. This is for, of course, office administrative and selling expenses.

MR. RICE: What would be the net profit?

MR. ANTOFT: The net profit of our company has been running from a minus figure to last year where we were able to show a profit on our trading of about below three-quarters of one per cent. It is not a good company to buy stock.

MR. RICE: How many people would you employ in your company?

MR. ANTOFT: Our total payroll at the present time is 25 people.

MR. RICE: How many of those people would

MR. RICE: How many of those people would

present time is 25 people.

MR. ANTORT: Our total payroll at the

employ in your company?

MR. RICE: How many people would you

company to pay stock.

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MR. ANTORT: The net profit of our company

MR. RICE: What would be the net profit?

course, office administrative and selling expenses.

approximately 4% of our gross sales. This is for, of

MR. ANTORT: Yes. Gross profit is

what percentage of the \$250,000.00 sales would be gross

MR. RICE: Could you tell us approximately

20% 25%.

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raw materials in your business?

amount of the \$250,000.00 would be required to purchase

MR. RICE: In all your programmes, what

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actual figure of what we purchase in the way of

MR. ANTORT: Well, I can give you the

be required for raw materials?



1
2 be involved directly in the manufacturing plant?

3 MR. ANTOST: There are 16 or 17.

4 MR. RICE: And how many of those people
5 would be university trained?

6 MR. ANTOST: We have three people who are
7 university trained.

8 MR. RICE: What degrees do they have?

9 MR. ANTOST: Our production manager holds
10 a Master of Science degree from the University of
11 Copenhagen in Pharmacy, and the microbiologist holds
12 a Master of Science degree in Biology, and we have
13 another technician who has had two years in university,
14 science.

15 MR. RICE: Could you tell the Committee,
16 give any comments on whether or not it is advisable
17 to market your products under a brand or trade name
18 rather than under a generic name?

19 MR. ANTOST: Well, because of the
20 complexity of generic names in our case we think that
21 it would add a good deal of confusion to attempt to
22 ask the doctors to prescribe under generic names.
23 We don't think it would make any difference pricewise
24 as far as our product is concerned, whether they were
25 prescribed under a generic name or brand name.

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prescribed under a generic name or brand name.



F/PB/dpw

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2 In the case of ACTH we are, to all intents
3 and purposes, the only manufacturer selling any volume
4 of ACTH in Canada. We think we have practically all
5 the market here. The only organization that has sold
6 ACTH under the brand name is Connaught Laboratories, and
7 they have recently indicated to us they were going to
8 stop manufacturing ACTH.

9 MR. RICE: Have you any figures on that
10 drug in particular since you are the only manufacturer
11 of that in Canada, as to what the profit would be on
12 that drug only?

13 MR. ANTOFT: Well, the percentage is the
14 same as I have indicated, that is the gross profit
15 before allowing for the cost of selling, administrative
16 costs, 45%.

17 MR. RICE: I take it from your previous
18 answer or statement it makes little difference whether
19 a product is manufactured under a brand name or a
20 generic name, the price would be the same?

21 MR. ANTOFT: I think in the case of our
22 products, which after all, are not imitations of other
23 products and which are very difficult for others to
24 imitate because it is a very complex operation which
25 you must have well-qualified people to work otherwise
26 it is impossible to manufacture.

27 I may mention that we are setting up a
28 subsidiary in the United States and I have been engaged
29 in the last few months in looking around for someone
30 in the United States who will sterile fill the

In the case of AGTH we are, to all intents and purposes, the only manufacturer selling any volume of AGTH in Canada. We think we have practically all the market here. The only organization that has sold AGTH under the brand name in Canada is Connaught Laboratories, and they have recently indicated to us they were going to stop manufacturing AGTH.

MR. RICE: Have you any figures on that drug in particular since you are the only manufacturer of that in Canada, as to what the profit would be on that?

MR. ANTOFT: Well, the percentage is the same as I have indicated, that is the gross profit before allowing for the cost of selling, administrative

MR. RICE: I take it from your previous answer or statement it makes little difference whether a product is manufactured under a brand name or a generic name, the price would be the same?

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I may mention that we are setting up a subsidiary in the United States and I have been engaged in the last few months in looking around for someone in the United States who will handle all the



1
2 injectable form of ACTH for us. During the course of
3 this investigation I have visited a number of plants
4 who do custom manufacturing and these plants are the
5 ones of the type that supply - use the other jobbers
6 or distributors with generic type of injectables. I
7 can say I have not yet found one that we, that would
8 be acceptable to us as a place to carry out this parti-
9 cular operation in our manufacturing. This, to me,
10 when I see some of the places that are filling injec-
11 tables and selling them in the United States, it would
12 give me pause before I would accept any form of injec-
13 table, any injectable drug, if any of my family or my
14 staff required it. I would be very loath to. I am
15 not talking about Canada. In Canada we have probably
16 a superior inspection system to what they have in the
17 United States. I think in the United States they are
18 going to have the same type of thing within the next
19 year or two, but at the present time any generic name
20 injectable, if you were to buy willy-nilly from a
21 druggist, I would certainly be very much afraid of
22 them.

23 I may mention some of the respects in
24 which these people wouldn't meet our specifications.
25 For example, I think in order to fill injectables you
26 must have a bacteriologist on your staff. It is incon-
27 ceivable to me how anyone could undertake to fill
28 sterile - an injectable without having a bacteriologist
29 supervising, not only the production procedures to
30 make sure that personnel are well aware of the things



injectable form of AOTH for us. During the course of this investigation I have visited a number of plants who do custom manufacturing and these plants are the ones of the type that supply - use the other jobbers or distributors with generic type of injectables. I can say I have not yet found one that we, that would be acceptable to us as a place to carry out this particular operation in our manufacturing. This, to me, when I see some of the places that are filling injectables and selling them in the United States, it would give me pause before I would accept any form of injectable, any injectable drug, if any of my family or my staff required it. I would be very loath to. I am not talking about Canada. In Canada we have probably a superior inspection system to what they have in the United States. I think in the United States they are going to have the same type of thing within the next year or two, but at the present time any generic name injectable, if you were to buy willfully from a druggist, I would certainly be very much afraid of them.

I may mention some of the respects in which your staff would be different from ours. For example, I think in order to fill injectables you must have a bacteriologist on your staff. It is inconceivable to me how anyone could undertake to fill sterile - an injectable without having a bacteriologist supervising, not only the production procedures to make sure that personnel are well aware of the things



1
2 that may cause contamination but also to carry out the
3 testing or the bacteriological control of condition of
4 sterile filling, and the rooms, and also the condition
5 of the finished product, this seems to me to be a mini-
6 mum requirement.

7 MR. BRYDEN: This raises a very important
8 problem that keeps cropping up here, the whole question
9 of how a person knows what is safe and what is not
10 safe to buy. The drug manufacturers and the Pharmaceu-
11 tical Manufacturers' Association tried to put it in
12 terms of brands. It seems to me a brand name is not
13 necessarily a guarantee of quality. Dr. Morrell of the
14 Food and Drug Directorate put it in the terms of we
15 have to know the manufacturer. That is fine for him,
16 he knows his manufacturers and he knows which ones are
17 good and which ones are not so good, but a layman like
18 myself does not know that. I suspect most doctors
19 don't really know it either. The great problem arises
20 - it puts the big fellows in a sort of monopoly position
21 and a small manufacturer such as yourself - I will
22 venture to use you as a possible example - might be
23 suspect even though you have good control procedure.
24 I will speak for myself, I never heard of your company
25 until you asked to come here. It seems to me to put
26 the big fellows who probably have good control procedure
27 in the position where they get a quasi-monopoly just
28 because the average person does not want to take a
29 chance on anyone. How can we get around that? Would
30 licensing of premises by the Government do it? You say



that was made available and also to keep the
 feeling as the industrialist would be in the
 hands of the State, and the State, and the
 of the United States, this seems to be a
 very important.

MR. BROWN: This seems a very important
 problem that has been brought up here, the whole question
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 sold to him. The drug manufacturers and the
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 licensing of products by the Government do it? You see



1
2 inspection procedures are better in Canada than in the
3 United States, but on the other hand they certainly
4 do not inspect each batch, that would be physically
5 impossible as I understand it.

6 MR. ANTIFT: In our own case, being
7 manufacturers of ACTH, this happens to be one of the
8 drugs that require a licence. We are required to
9 operate to the specifications that are set for us by
10 the Dominion Government. I think that is a good thing.
11 I think a manufacturer who is permitted to put a
12 licence number on his product which shows he is under
13 control by the Federal authority, that this in itself
14 would give me ample confidence, knowing the Federal
15 inspectors and the personnel of the Federal Food and
16 Drug Directorate. This would give me ample confidence.
17 As far as manufacturers who are not subject to inspec-
18 tion, I think probably the tendency should be and is
19 towards bringing these under closer control and that
20 is all for the good because as an ethical drug manufac-
21 turer I am very interested in seeing the marginal
22 operators out of the picture. I wouldn't like to
23 compete in marketing on a product, an injectable, with
24 somebody who does not have to go to the expense of
25 maintaining the bacteriological control laboratory.
26 They naturally could under-quote me.

27 MR. BRYDEN: You say the fact you happen
28 to be producing in that fairly limited area where a
29 licence is required by law that helps you to get your
30 reputation established, the fact you do have a licence,



inspection procedures are better in Canada than in the United States, but on the other hand they certainly do not inspect each batch, that would be physically impossible as I understand it.

MR. AMOY: In our own case, being manufacturers of A.T.H., this happens to be one of the drugs that require a licence. We are required to operate to the specifications that are set for us by the Dominion Government. I think that is a good thing.

I think it is important to note that the licence number on his product which shows he is under control by the Federal authority, that this in itself would give me ample confidence.

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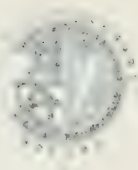
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2 that licence would give people confidence in you?

3 MR. ANTOFT: I think that is true. I
4 think that is true. The question of a small company
5 and a new company building its reputation is a very
6 long, tedious and expensive proposition, but I think
7 when you are operating in the field where you are
8 licensed that the question is somewhat simpler. I
9 don't know what the full answer is. Obviously it is
10 impossible for the Government to inspect each batch
11 of any drug. As Dr. Morrell says the individual
12 manufacturer's reputation counts for a lot. I think
13 that generally a large part of the medical profession
14 knows which manufacturer that he can rely on. There
15 may be some instances, but all in all, I would like to
16 emphasize I don't believe that size by itself dictates
17 quality.

18 MR. BRYDEN: There is a bit of a tendency
19 for the public to assume, and after all, the doctor is
20 a member of the public, to assume because a company is
21 a big one it will put out a good product and some, I
22 suspect, some of the confidence that doctors have is
23 built up on successful promotion directed towards him
24 rather than on the basis of anything they do. They,
2 25 after all, have not inspected the plant and probably
26 wouldn't be qualified to inspect it in any event.

27 MR. ANTOFT: I agree with that, this is
28 a major problem that does face both the public and also
29 the drug manufacturers.

30 MR. WREN: You expressed some concern



that license would give people confidence in you?

MR. ANTON: I think that is true. I

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1 about injectables produced in the United States, I
2 would assume a lot of these are imported in Canada.

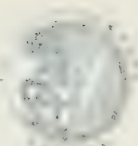
3
4 MR. ANTOFT: I have no data on who exports
5 injectables into Canada or if any of the plants that
6 I visited, if they export injectables into Canada. I
7 don't know. I do know that if, that of course if they
8 did export sub-standard products into Canada the
9 Canadian government would very rapidly see that they
10 didn't do so once they became aware of it.

11 MR. WREN: In the plants you looked at
12 and expressed some concern about would you think their
13 product is going entirely to the United States market?

14 MR. ANTOFT: I know that some of them
15 operate in the export field, but I don't know if any
16 of them export in Canada.

17 MR. BRYDEN: Is that an area where a
18 licence would be required?

19 MR. ANTOFT: No, injectables as such are
20 not yet required to, but I believe that the Canadian
21 Food and Drug Directorate feels they should eventually
22 all be brought under licence in Canada. I think this
23 will be the answer. I think in the case of non-injec-
24 tables the problems are probably much less because
25 providing that a manufacturer operates with clean
26 premises, even though the variations - there may be
27 variations in potency itself - it is not as critical
28 as an injectable that may not be sterile or may be
29 pyrogenic or may not have adequate control to see
30 somebody, somewhere along the way has not made a



about injectables produced in the United States. I would assume a lot of these are imported in Canada.

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MR. WHEAT: In the plants you looked at

and expressed some concern about would you think their product is going entirely to the United States market? MR. ANTOFT: I know that some of them

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2 mistake. All people are human and for the purposes of
3 our quality control in our plant it is to make sure
4 if there has been an error there is 100% assurance it is
5 caught before the product becomes released.

6 MR. PRICE: You have expressed some
7 concern over the results of your visits to some plants
8 in the United States. Have you visited any plants in
9 Canada?

10 MR. ANTOFT: Well, I have during the
11 course of my association with the pharmaceutical industry
12 been in a lot of Canadian plants. Most of the Canadian
13 plants that operate in the field of injectables are
14 quite large and are licensed and they operate on what
15 I would consider to be good standard.

16 MR. PRICE: Have you noticed anything in
17 those plants that produced products other than injec-
18 tables, anything that you would consider sub-standard?

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our quality control in our plant it is to make sure
if there has been an error there in 10% assurance it is
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in the United States. Have you visited any plants in

MR. AMESBURY: Well, I have during the
course of my association with the pharmaceutical industry
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MR. PRINCE: Have you noticed anything in
those plants that produced products other than injec-



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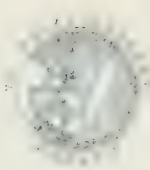
When I have at times visited the small manufacturers, I would sort of look at individual things and say this is a little sloppy. I think this is poor manufacturing procedure.

MR. RICE: Would it be to the extent of alarming you, though?

MR. ANTOfT: I haven't gone into it enough to be qualified to express an opinion.

MR. RICE: Another part in your brief you indicated you spend about 35% of your gross sales on this promotion and sales programme which I take you would like to get away from. Is there any other type of programme you could suggest for the manufacturers to educate the doctors, as it were, to their products; advertising their products other than the programmes that have been undertaken here, the detail men and sampling, and so on.

MR. ANTOfT: I wish I did. It's a problem for us and for our detail men, the fact that the doctors are getting more and more sort of generally resistant to seeing salesmen. For example, if a company makes a policy of saying to its salesmen you must see every doctor in your territory at least once every three weeks or once every four weeks, regardless of whether or not the salesman has anything particularly new to talk about, then when you have 40 or 50 companies who are all competing to that extent for the doctor's attention, then when our very sparse detail force come around perhaps for their yearly or six-monthly visit



When I have at times visited the small

manufacturers, I would sort of look at individual things and say this is a little sloppy. I think this is poor manufacturing procedure.

MR. RICE: Would it be to the extent of

startling you, though?

MR. ANTOFT: I haven't gone into it

enough to be qualified to express an opinion.

MR. RICE: Another part in your brief you

indicated you spend about 25% of your gross sales on

this promotion and sales programme which I take you

would like to get away from. Is there any other type

of programme you could suggest for the manufacturers

to educate the doctors, as it were, to their products;

advertising their products other than the programmes

that have been undertaken here, the detail men and

assembly, and so on.

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2 to the doctor and they generally have something with
3 them worthwhile to bring to his attention and in a
4 very specialized field, he is put into the same category
5 with the other fellow that came pushing vitamins. He
6 is made to wait the same length of time. He is turned
7 away the same number of times; maybe turned away even
8 more frequently because being a comparatively small
9 and not well-known company the doctor has said to his
10 nurse: "I will see the man from A, B, C., and D, but
11 all the others I don't want to bother with."

12 This is the thing that makes it very
13 expensive when a salesman can only make five or six
14 calls in a day. Naturally this is adding to the cost
15 of the programme. This is a field in which I think
16 the pharmaceutical industry and medical associations
17 are eventually going to be forced to sit down together
18 and try to work out some programme of putting information
19 across to doctors on a less expensive basis.

20 MR. WREN: You would have to be rather
21 an astute individual to impress profit on the pharmacist
22 and service on the doctor. What I was interested in
23 too in your brief was when you mentioned methods used
24 in Denmark. I presume you visited the country and
25 know something about it. Is the professional pharmacist
26 held in any less respect as a professional man by
27 the fact that he devotes his time almost entirely to
28 the professional aspect?

29 MR. ANTIFT: I think generally that the
30 professional standing of a Danish pharmacist is considerably



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2 higher. He is held in much higher respect as a academic
3 person and as a professional person than he is in
4 Canada. You don't see in the Danish trade journals,
5 you don't see these editorials devoted to the need of
6 public relations to convince the public that we are
7 professional people. You don't see anything of that
8 type.

9 MR. WREN: Do they themselves feel that
10 they are tools of the State by any stretch of the
11 imagination, or do they feel they are free professional
12 men?

13 MR. ANTOST: I think that that varies
14 with the individual. I think that the pharmacist, the
15 Danish pharmacists that we have in Canada, would be
16 loath to go back to Denmark and go into a drug store
17 where his life is very ordered for him.

18 He knows exactly what age he will be
19 eligible to run his own pharmacy. This is not dictated
20 by his initiative or his enterprise or anything. This
21 is dictated by his seniority and what year he graduated
22 and the time he becomes eligible he files an application
23 to manage a drug store. If they find his record has
24 been good, and so on, they grant him a licence to
25 manage, to buy inventory and manage one of these drug
26 stores that are allowed by Royal Decree.

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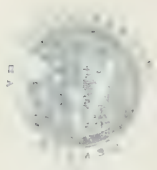
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1 We have heard evidence to the effect that in order to
2 get into this business it involves considerable capital
3 both in plant and research, particularly. Now this
4 also has been stressed that a great many of these
5 drugs now in use require millions in plant and millions
6 in research before they could be put on the market.
7 Do you know of any drugs, new drugs so-called that
8 require these millions in plant and research to get
9 onto the market in a safe condition?
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11 MR. ANTIFT: Well it is of course true
12 that the tendency has been for drug companies, I am
13 thinking particularly of American Drug companies to set
14 up very large research activities in which they engage
15 in screening a large number of drugs and a lot of this
16 leads into blind alleys, and to that extent, yes, I
17 think that it is true that many of the drugs that we
18 have are the result of spending many millions of
19 dollars on research.

20 I also think that many of the drugs that
21 we have today are the result of people like Banting
22 who worked with a very limited budget and who, as the
23 result had to use his imagination to the utmost. I
24 think that this is a factor that the larger companies
25 are overlooking, to their peril. They make research
26 workers into operators of complex gadgets and they
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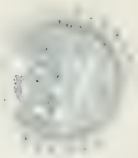


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2 MR. WREN: From attending conventions
3 and discussing this with people in the field, have you
4 any idea of how many useful new drugs have been developed
5 by either State or private endowment, fellowship and
6 the like as compared with those that have been developed
7 by purely manufacturers' research?

8 MR. ANTOST: Of course, many of these
9 things are co-operative ventures. For example, the
10 drug cortisone. This was something that started back
11 in the 30's with workers in university centres
12 gradually bringing a little more and a little more
13 knowledge of this to this particular group of substance
14 but then I think that in this case it was a pharma-
15 ceutical house, Merc who, because they did not have
16 to worry too much about budgets, were able to eventually
17 bring it to the point where somebody was going to
18 try it and discover what it could be used for, and then
19 later on to get it into mass production.

20 MR. WREN: This is the point: Was their
21 activity largely one of developing machinery of mass
22 production or was their activity one largely of
23 developing the initial products?

24 MR. ANTOST: Well I think it would be
25 fair to say that a large part of their contribution
26 was in developing the machinery. But this is not true
27 of -- there is no set pattern. In other words you
28 can't generalize and say well all drugs are discovered
29 in the university and are put into production by
30 industry because this is certainly not any set pattern.



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5 MR. WREN: There are the dedicated
6 pharmacists, dedicated manufacturers in any field; one
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8 MR. ANTOFT: The point I would also like
9 to make is it seems to me that the tendency is for
10 more scientists to go into industry and I think that
11 this is something that should be encouraged more in
12 Canada than it is.

13 It is fairly difficult in Canada for
14 Canadian companies to induce a top flight person to
15 go into industry. It isn't so in the United States.
16 Now you have many of the most respected research workers
17 in the field of basic science who are with pharmaceutical
18 companies or who at some time during their career go
19 through pharmaceutical companies.

20 MR. TROTTER: Don't some of the large
21 firms in the States receive grants from the Government?

22 MR. ANTOFT: Yes. This is the point I
23 am making in my brief that in the United States, for
24 example, I took the example of Cancer Screening Program
25 in which the National Institute of Health selected
26 various of the large and medium sized pharmaceutical
27 companies who were equipped with personnel and with
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2 MR. WREN: Does the Government in that
3 case recover any of that money or is that a straight
4 grant?

5 MR. ANTOFT: Well usually this is a
6 development contract. What eventually happens, whether
7 there is any commercial benefit to anybody and who
8 this commercial benefit will accrue for, is not made
9 the crux of the matter.

10 MR. BRYDEN: Isn't that a problem that
11 has been developing? For example, penicillin was one
12 of the first instances that I think of government-
13 industry co-operation in a crash programme to put it
14 into production basis as a wartime project. Penicillin
15 has always been an inexpensive drug because it has
16 always been part of the public domain. I understand
17 that with this Cancer Screening Program they ran into
18 a lot of trouble. The companies were holding out unless
19 they got patents -- at least unless they got the right
20 to patent anything they might happen to come across,
21 they could patent it and thereby get an exclusive,
22 to some degree on it, and that actually it isn't like
23 the penicillin programme. They have been asserting
24 a lot of commercial right in it and threatening to
25 slow down the programme if they didn't get them. Now
26 is that a fact or not? That is an impression I get
27 from reading about it.

28 MR. ANTOFT: I wouldn't say that this
29 is sort of the general rule of this Cancer Screening
30 Program. I think while you will have companies who



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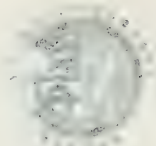
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1 start worrying about their commercial stake in this, but
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4 this thing we will go along with it and certainly if
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6 some sort of priority to start manufacturing. I think
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9 of government-private-industry co-operation and I myself
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13 I think that they generally tend to slow
14 up development. We don't depend on patents in our
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16 compete with us well they are perfectly at liberty to
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INDUSTRY

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MR. TROTTER: Has your firm any patents?

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MR. ANTOFT: Yes, we hold one patent.

4

MR. TROTTER: In page 3 of your brief you mention the work of Dr. E.B. Astwood in Boston, and I think as a result of his work your firm has been able to operate. Were his discoveries the result of work done through government grants, or private industry?

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MR. ANTOFT: He is the Chief in Medicine at the New England Medical Centre, and is professor in Medicine at the Tuft's Medical School.

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We have for many years worked with him. A few days ago, speaking about a new area in which we hope to co-operate with Dr. Astwood. Dr. Astwood has not patented his discoveries, as do no academical medical researchers, and naturally we owe a great debt of gratitude, all of us do, not only in my company but all of us of humanity, to people like Astwood, who develop ideas like this that we in our specialized field can take up.

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MR. TROTTER: He in other words would be largely supported through the government grants?

23

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MR. ANTOFT: That is right, he does receive support in the way of materials and so on from several commercial firms in the United States, and without this he probably would have been unable to do what he is doing.

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MR. TROTTER: Is there such a thing in the production of drugs where a firm can get too large? In other words, that a firm reaches the size where it is



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1 too costly to produce?

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3 MR. ANTOFT: Yes, I think that is a very
4 fair observation. I have seen some of my colleagues
5 in the drug industry who have become so large and
6 cumbersome and weighted down with paperwork, that it
7 is very costly. I think this is the reason why Merc
8 closed down in Valleyfield.

9 MR. TROTTER: Do you find that, everything
10 being equal as far as quality is concerned, your small
11 firm can produce ACTH cheaper than anybody else in
12 Canada?

13 MR. ANTOFT: Well, our list price may not
14 be cheaper in the case of Connaught Laboratories, but
15 they are going out of the business obviously because
16 of the heavy drain on their resources.

17 MR. TROTTER: When you found that you
18 started to succeed in this product, has there been any
19 pressure on you, either directly or indirectly, by
20 large firms to sell out to them?

21 MR. ANTOFT: No, there has been no
22 pressure. We have been at various times asked if we
23 were for sale.

24 MR. TROTTER: Does there seem to be a
25 tendency in the drug industry that when a small firm
26 gets established, has got something good and are
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29 MR. ANTOFT: Yes, that is the general
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4 he be forced to sell out, or forced out of the market?

5 MR. ANTOFT: No, in our case we have no
6 intention of selling out, or of being forced out of
7 the market either. I don't think that this is a serious
8 consideration.

9 MR. BRYDEN: Promotion, it becomes rela-
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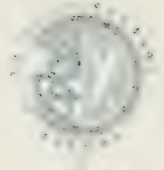
12 MR. ANTOFT: Yes, there is great pressure
13 on us to handle additional products, to keep our
14 organization growing --

15 MR. WHITE: What percentage of drugs
16 that you sell do you manufacture in your own plant?

17 MR. ANTOFT: Approximately I would say
18 about 90%.

19 MR. BRYDEN: Are there any other companies
20 that you know of in Canada that it would be more than
21 half of the drugs that they manufacture?

22 MR. ANTOFT: No, there are very few basic
23 manufacturers in Canada, and I think this is the weak-
24 ness of the Canadian pharmaceutical industry. The one
25 basic manufacturer on a large scale that we did have
26 in the Merc plant in Valleyfield manufactured B.12 and
27 hydrocortisone, and at one time penicillin. This was
28 to me a sad day for the Canadian pharmaceutical industry
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1 to exist..

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3 MR. BRYDEN: What about Fine Chemicals?

4 MR. ANTOFT: Fine Chemicals are a basic
5 manufacturer, and although I don't know them too well --

6 MR. BRYDEN: They just manufacture for
7 others?

8 MR. ANTOFT: Yes, and we have several
9 like that in Canada, and Delmar Chemicals in Montreal,
10 which is a basic manufacturer, but there are very few
11 of them.

12 MR. WREN: Would it be your general
13 observation from your own experience that if the
14 Canadian investor were more knowledgeable about drug
15 manufacturing potential in Canada, that a self-sustaining
16 industry could be established in Canada?

17 MR. ANTOFT: Yes, very definitely. I
18 feel the opportunities for a drug industry in Canada
19 provided that it does more than just re-package,
20 provided that it sets out consciously to work with the
21 people we have in Canadian universities, if we work
22 together with these people, I am sure that we could
23 build a native pharmaceutical industry that is both
24 basic and prosperous, and that will contribute to --

25 MR. WREN: Up to now, and this is just
26 my own opinion, it seems to me that there has been an
27 aura of mystery about this industry. In other words,
28 it was something which only the very learned could have
29 anything to do with, involving great risks both profes-
30 sionally and financially. In your own experience, you



to exist.

MR. BRYDEN: What about Fine Chemicals?

MR. ANTORT: Fine Chemicals are a basic

manufacture, and although I don't know them too well --

MR. BRYDEN: They just manufacture for

MR. ANTORT: Yes, and we have several

like that in Canada, and Delmar Chemicals in Montreal,

which is a basic manufacturer, but there are very few

MR. WHEAT: Would it be your general

observation from your own experience that if the

manufacturing potential in Canada, that a self-sustaining

industry could be established in Canada?

MR. ANTORT: Yes, very definitely. I

feel the opportunities for a drug industry in Canada

provided that it does more than just re-package,

provided that it sets out consciously to work with the

people we have in Canadian universities, if we work

together with these people, I am sure that we could

build a native pharmaceutical industry that is both

basic and prosperous, and that will contribute to --

MR. WHEAT: Up to now, and this is just

my own opinion, it seems to me that there has been an

aura of mystery about this industry. In other words,

it was something which only the very learned could have

anything to do with, involving great risks both profes-

sionally and financially. In your own experience, you



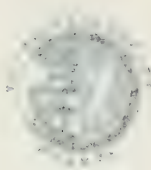
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3 aviation industry, would it be your experience that
4 anyone with capital who made proper investigation would
5 find that Canadian production was possible and profi-
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7 MR. ANTOfT: Yes, I would be wholly in
8 agreement with that.

9 MR. BRYDEN: Would you say that Canadian
10 patent laws militate against the development of a
11 domestic industry significantly?

12 MR. ANTOfT: No, I don't think so. I
13 think the Canadian patent laws are not a particular
14 influence one way or the other. If I have a good idea,
15 regardless of whether or not I can get it patented, if
16 I get it on the market a year or so ahead of anybody
17 else, then there is enough support from the Canadian
18 medical profession. They are going to respect that I
19 was the first one to put it on the market, and I am
20 still going to get enough loyalty from the people in
21 the profession. I am not going to suffer unduly.

22 MR. BRYDEN: I am looking at it from the
23 other point of view, that the American company comes
24 up here with a patent and it has an exclusive. Now
25 I know theoretically under the law there are possibili-
26 ties of getting licences, but those possibilities seem
27 to be very rarely experienced. In Italy, as I under-
28 stand it, you cannot patent drugs, or not very much.
29 Why should somebody patent what is really just the
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2 MR. WHITE: Your sales are largely the
3 cortisone that you have developed?

4 MR. ANTOFT: ACTH.

5 MR. WHITE: Have you a patent on that?

6 MR. ANTOFT: No, we did have a patent
7 pending, but this has been dropped.

8 MR. WHITE: Because it was not patentable,
9 or you decided you didn't want to patent it?

10 MR. ANTOFT: We decided we didn't want to
11 patent it.

12 MR. TROTTER: If you felt that a patent,
13 if you had a new idea and got on the market a year
14 ahead, do you feel you could still hold that, despite
15 the fact somebody had much more capital, could you be
16 forced out of the market?

17 MR. ANTOFT: I think we were the first
18 to think of the idea of putting hydrocortisone into a
19 suppository to treat local inflammations of the rectal
20 area. Very shortly after we put that on the market,
21 we were flooded with imitators. We still maintain a
22 very sizeable sale of this product, we haven't the
23 majority of the market, but our market has not declined
24 as a result of that competition. The fact that our
25 salesmen can say: "You can see this is a good idea
26 because there are so many people copied it".

27 MR. TROTTER: When you sell drugs in
28 bulk, the greater the order the cheaper the price,
29 does that follow?

2 30 MR. ANTOFT: Only in some cases. In the



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3 MR. TROTTER: In other words, if a man
4 had one drug store or a chain of twenty drug stores,
5 what he pays to you makes no difference?

6 MR. ANTOFT: No. We have package sizes
7 of course. In some of our other products depending
8 whether he buys a package of five or a hundred units,
9 naturally our production, selling and shipping costs
10 and so on are lower on the larger units. We sell a
11 bulk package at a proportionately lower cost, but as
12 far as giving a better discount to a group of drug
13 stores, unless the drug stores operate as a wholesale
14 house or have a wholesale subsidiary which buys for
15 them, which is recognized in the trade as a wholesaler,
16 we wouldn't give them any price discount on the basis
17 of the size of the purchase.

18 MR. BOYER: You mean your unit price is
19 the same for a hundred, a thousand, or ten thousand?

20 MR. ANTOFT: In the case of our injectables,
21 yes, it is the same.

22 MR. TROTTER: Whether it holds in your
23 case or not, would you say that looking at the retail
24 sale of drugs as a whole, could not a chain store or
25 a group of stores sell more cheaply than a smaller
26 store, the independent operator? This is just in the
27 sale of drugs?

28 MR. ANTOFT: Probably they could. Of
29 course, they are under considerable pressure not to
30 cut prices from their own colleagues.



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2 MR. TROTTER: But from a business point
3 of view, and disregarding the pressures for the moment,
4 it is possible to retail drugs at a lower price if
5 you can have a mass market, a mass outlet such as
6 chain stores?

7 MR. ANTOFT: I would assume so. This
8 sounds logical. I have no personal experience.

9 MR. WREN: This tendency for manufacturers
10 to use brand names, largely I suppose to convenience
11 the medical profession, as was asked yesterday by one
12 of my colleagues on this Committee, why couldn't you
13 go a step farther, if it is just for convenience, and use
14 numbers, 1, 2, 3, 4, and catalogue the ingredients by
15 numbers, cross-catalogue?

16 MR. ANTOFT: I think that if you put out
17 your catalogue as a telephone directory it would be
18 very difficult for the doctors to remember the names,
19 or remember the numbers of the particular prescriptions
20 that he wishes, and I think that the possibilities of
21 error would be very much greater if he were to say
22 well, such-and-such a tablet, that is No. 537. Brand
23 names are largely a matter of convenience I think. I
24 think it is a way of trying to make it easier for the
25 doctor to remember what it is he has to prescribe.

26 You might be interested in what they
27 are doing in Scandinavia. I don't know exactly how
28 far they have gone, and whether the law has gone into
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30 the Danish and Swedish papers about this. The proposal



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ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Antoft

1914

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2 under a trade name, for sale under a trade name, and
3 all other later drugs which were imitations of this
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2 As, for example, the first person who thought of
3 acetylsalicylic acid would be allowed to sell it under
4 the brand name of "Aspirin". All others who came later
5 who merely copied this product, they were required to
6 deal with it as acetylsalicylic acid.

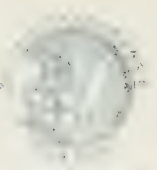
7 MR. WREN: Why was the proposal made?

8 MR. ANTOST: This was to cut down on
9 the vast number of trade names that the manufacturers
10 were trying to force onto the doctors.

11 MR. BRYDEN: Isn't that the problem of
12 the brand name, it creates confusion? The doctor is
13 a busy man; I don't know how he can possibly keep up
14 with them. Isn't there a possibility of developing
15 an official language which is not a trade name language
16 but a simplification of these very complicated terms
17 which would become standardized, just an official name
18 of the product?

19 MR. ANTOST: That is a possibility, if
20 at the same time that you could assure that the
21 manufacturer who is allowed to operate or does operate
22 in this field is one who operates under standards --
23 the only objection I would have to this is that it
24 sounds as if this proposal would entail a tremendous
25 amount of government control and supervision and all
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27 MR. BRYDEN: You might have one group
28 of people racking their brains to find simplified names
29 rather than have a whole series of them. Actually it
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6 MR. ANTOFT: Yes. But in the case of
7 drugs, whether one ingredient formula which is proposed
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9 our own preparation, for example, we have had cortisone
10 in a topical solution, and we have no comparable
11 product because most of the other manufacturers
12 content themselves with having the suspension form.
13 In other words, the material is in a different formulation
14 form. If the doctor has to write hydro cortisone
15 solution, this is a cumbersome thing for him. It is
16 more specific that he knows a product which is called
17 Cortinant. If you were to say that all topical hydro
18 cortisones shall be listed under the one name of
19 "Aid" or something like that, I don't see exactly how
20 the doctor is going to differentiate.

21 MR. BRYDEN: Sometimes the differentiation
22 may not be so significant in therapy as the detail
23 man has made out.

24 MR. ANTOFT: Yes. This is one of the
25 problems, that the detail man, trying to make an
26 impression on the doctor, tends to exaggerate. I
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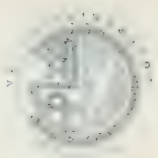
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6 create a product for the market. I think these are
7 the people who do a disservice to the pharmaceutical
8 industry. I think that to me --

9 MR. TROTTER: There is a lot of that,
10 though, isn't there?

11 MR. ANTOFT: There is a lot of that. I
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13 MR. BRYDEN: Is there any possibility that
14 in this country the industry, the medical profession for
15 example, perhaps with encouragement from the government,
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17 publication which would give doctors the information
18 without promotion. It is an independent organization
19 which puts this out in the United States. There is one
20 in the United States; it is called "The Medical Letter".
21 It is a straight, colourless document, and it would
22 seem to me that an awful lot of those promotional
23 excesses would be greatly reduced if there was a genuinely
24 independent organization or group of qualified people.

25 MR. ANTOFT: I hope that the type of
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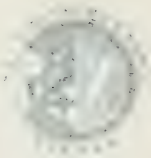
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5 MR. WREN: We have heard evidence where
6 the doctor is the prime mover in all this field of
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8 directs whether the patient shall or shall not get the
9 drugs, and yet he spends relatively little more time in
10 university than the pharmacist and he has to learn a
11 whole host of other things besides, psychiatrics,
12 gynaecology, and so on. Yet the manufacturer is getting
13 to the point where they are labelling their drugs where
14 the pharmacists needs very little of the trade in which
15 he has spent so much time training, and it surprises me
16 that they need all this apprenticeship, because the
17 doctor is the key factor in this.

18 MR. ANTOFT: I think that this is the
19 crux of a large part of the problem, the fact that the
20 pharmacist is no longer functioning mainly as a pharmacist.
21 He should be qualified by his training to advise the
22 doctors, but when he is subjected to this type of
23 advertising, as I pointed out to you, if you push my
24 product you are going to make more money than if you
25 push another product. If I were a pharmacist myself
26 I would find it insulting and I would, if I could,
27 divorce myself from subconsciously succumbing to this
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30 I have gone to the university for four years and have



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4 MR. TROTTER: Could it not possibly be said
5 that most of the cost of pushing drugs comes not from
6 the druggist or pharmacist but from the manufacturer?

7 MR. ANTOST: Yes. It is a unique industry.
8 When you are selling appliances the major part of the
9 cost of selling comes from the consumer. You must
10 remember that in the pharmaceutical industry this is
11 one instance where practically all the selling costs
12 are at the manufacturer's level. The druggist doesn't
13 advertise any ethical drug, he is not permitted to,
14 and he takes no part whatsoever in the selling of these. It
15 may be if you investigated any other field that you find
16 that the promotional cost all along the way is exactly
17 the same or may even be higher, but it is spread out
18 in the various channels from wholesaler to retailer
19 and the manufacturer only carries only a small amount,
20 but in our industry the manufacturer carries almost
21 one hundred per cent of the selling cost. You should
22 keep in mind this industry is somewhat unique.

23 MR. BRYDEN: The huckstering industry
24 is another unique one, yet the same sort of tricks are
25 used.

26 MR. TROTTER: You told us that 9% of
27 your gross sales are spent on research and quality
28 control. Would that be about the similar rate that
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30 MR. ANTOST: According to the published



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1 figures that appear from time to time in the trade
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4

5 MR. TROTTER: If your percentage is higher,
6 would it not be correct to say that the large drug
7 companies seem to overdo their claims as to the very
8 high cost as a result of research?

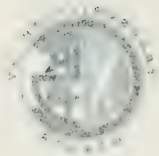
9 MR. ANTOFT: Since they are on the
10 defensive, they may use this.

11 MR. TROTTER: Before the Commission in
12 the United States that seemed to be their excuse?

13 MR. ANTOFT: I would not say that research
14 is the cause for high prices. I would say it is
15 getting the information across to the doctor is the
16 main reason.

17 MR. TROTTER: From what you have told us,
18 in your firm you are not obviously making a huge
19 profit. Could you give us some explanation of why these
20 drug firms in the larger ones seem to be making, in
21 the last few years particularly, a tremendous profit?
22 Would it be because of mass production, or what would
23 be the reason?

24 MR. ANTOFT: When you get into a large
25 enough volume where you can spread your overhead over
26 large sales -- this will happen to us as we grow up,
27 that our profit picture improves. I hope to get some
28 return on my investment and I hope we will get into a
29 situation where we are making a profit that is
30 sufficient to induce additional investment in our company.



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MR. TROTTER: If your percentage is higher,

would it not be correct to say that the large drug companies seem to overdo their claims as to the very high cost as a result of research?

MR. ANTOFT: Since they are on the

defensive, they may use this.

MR. TROTTER: Before the Commission in

the United States that seemed to be their excuse?

MR. ANTOFT: I would not say that research

is the cause for high prices. I would say it is

getting the information across to the doctor is the

main reason.

MR. TROTTER: From what you have told us,

in your firm you are not obviously making a huge

profit. Could you give us some explanation of why these

drug firms in the larger ones seem to be making, in

the last few years particularly, a tremendous profit?

Would it be, because of mass production, or what would

be the reason?

MR. ANTOFT: When you get into a large

enough volume where you can spread your overhead over

large sales -- this will happen to us as we grow up,

that our profit picture improves. I hope to get some

return on my investment and I hope we will get into a

situation where we are making a profit that is

sufficient to induce additional investment in our company.



1 Although I believe that the pharmaceutical industry's
2 average earnings during the past decade have been
3 higher than in any single industry. This is not
4 necessarily a permanent situation. I think in the
5 last few years, when the development of new drugs has
6 slowed down, that there are companies who are fighting
7 to maintain their position. I think Merck closed down
8 a plant employing 350 or 400 people, but the fact that
9 they couldn't find it profitable to maintain that shows
10 that it is not entirely true to say that it is such a
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12 same commercial risks you have in other industries.
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MR. BRYDEN: This could be a high margin industry with profit being eaten away by more and more promotion. An article in Fortune seemed to indicate that with no new discoveries they are eating each other with promotional costs.

MR. RICE: Have you any reason for not belonging to the Drug Manufacturers' Association here in Canada?

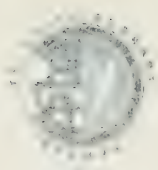
MR. ANTOFT: Yes, again I would like to speak off the record.

MR. RICE: You can't do that, I am sorry.

MR. ANTOFT: As far as the press is concerned, if I may.

MR. RICE: You will have to rely on the courtesy of the press for that.

MR. ANTOFT: I will take my chances then. We were invited some years ago to join the Canadian Pharmaceutical Manufacturers' Association. At that time we thought it would be a very good idea, however, right after our application was submitted and accepted the membership fee was jacked up from something like \$75 a year up to \$400 or \$500. I forget the exact figure, but it would have cost us some fee out of proportion to what we might get out of it. The explanation at that time was that the Canadian Pharmaceutical Manufacturers' Association felt they should embark on an extensive public relations programme to improve the relationship between the public and the industry. We felt this was an area in which we had no specific



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MR. BRYDEN: This could be a high margin industry with profit being eaten away by more and more promotion. An article in Fortune seemed to indicate that with no new investments they are sitting on their hands with promotional costs.

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2 interest one way or the other, so we didn't go in.

3 MR. WREN: There was no ethical reason?

4 MR. ANTIFT: No ethical reason. The
5 Canadian Pharmaceutical Manufacturers' Association does
6 carry out some very worthwhile activities we would like
7 to have participated in, particularly on the scientific
8 level, but we felt that the membership fee that we were
9 expected to pay, in proportion to our size, was just
10 unreasonable.

11 MR. WREN: Like M.P.P.'s expenses being
12 out of proportion.

13 MR. TROTTER: Would you care to venture
14 an opinion on Italian drugs that are being imported into
15 Canada?

16 MR. ANTIFT: I don't have very much
17 experience with them. I only know the industry shop
18 talk. Some of these Italian firms are quite serious.
19 They are probably a fairly mixed lot.

20 MR. TROTTER: Do you know of any bad
21 effect it has had on people or people's health?

22 MR. ANTIFT: No.

23 THE CHAIRMAN: Gentlemen, I believe we
24 have had a fairly long period of questioning Mr.
25 Antoft. I believe some of the Committee have to leave
26 fairly early. It is now 12.30. If there are any
27 important questions directly affecting the cost of
28 drugs, one or two questions, perhaps we could permit
29 another five minutes. It is now 12.30 and Mr. Boyer
30 has already had to leave. Are there many more questions?

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2 MR. TROTTER: I have one, a rather
3 general question. Do you find in hiring trained help
4 in your industry or getting trained help, is there a
5 tendency of our best help to go to the United States,
6 our trained university help?

7 MR. ANTOFT: Yes, I feel that is true.

8 MR. TROTTER: Do you find that difficulty
9 in your firm?

10 MR. ANTOFT: No, since we only have two
11 or three key people it is no great problem, but I
12 imagine the day we have to go out and find 20 or 25
13 Masters of Science or Ph.D's I would then think we
14 would experience difficulty because of competition from
15 the United States.

16 MR. TROTTER: Would the answer be in
17 Canada we cannot afford to pay high prices, high wages?

18 MR. ANTOFT: Whether we can afford it or
19 not, we are not paying them and for that reason these
20 people are going to the United States. Although the
21 individual industry may be willing to pay for properly
22 qualified personnel there isn't a pool of personnel to
23 draw from because many of them already are in the
24 United States.

25 MR. RICE: To keep the record straight,
26 this price list you filed, that is suggested retail?

27 MR. ANTOFT: List price.

28 MR. RICE: Suggested retail prices that
29 the pharmacists charge or that you charge?

30 MR. ANTOFT: We give 40% discount to the



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MR. ANTOFF: We give 10% discount to the



1 pharmacist.

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3 MR. RICE: You sell to the pharmacist
4 directly or to the wholesaler?

5 MR. ANTOFT: We do, if he places an order
6 directly, but most of our business with a pharmacist
7 goes through a wholesaler.

8 MR. RICE: Do you sell to any institutions
9 directly?

10 MR. ANTOFT: Yes, we sell directly to
11 the hospitals, we deal directly.

12 MR. RICE: When you sell to the whole-
13 saler, I take it you give him an additional discount
14 from the 40%, can you tell us what that additional is?

15 MR. ANTOFT: 16.2/3.

16 MR. WHITE: Is that a standard wholesale
17 discount?

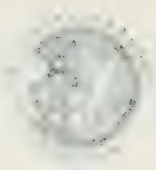
18 MR. ANTOFT: In our case or in the case
19 of the industry? It is general, it says - it is pretty
20 well a standard discount.

21 MR. WHITE: If a retailer was purchasing
22 your drug through a wholesaler or from you directly
23 he would get the same price?

24 MR. ANTOFT: That is right.

25 MR. WHITE: There wouldn't be any advan-
26 tage?

27 MR. ANTOFT: We encourage purchasing
28 through a wholesaler. It is less expensive for us.
29 In other words, the 16.2/3% - the wholesaler looks
30 after the small shipment, takes credit risks in



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1 dealing with individual drugstores and so on.

2 MR. RICE: Institutions, what price do
3 you sell to them at, the price you sell to a wholesaler?

4 MR. ANTOfT: No, list less 40%.

5 MR. RICE: A hospital gets 40% less.

6 MR. ANTOfT: Yes.

7 MR. RICE: Do these prices prevail
8 throughout Canada or do you change in one place or
9 another?

10 MR. ANTOfT: In Western Canada where we
11 distribute through a distributor we don't exercise
12 any control on discount they give. If a doctor buys
13 we give a doctor 40% whereas the Steven's Company only
14 gives a doctor 25%.

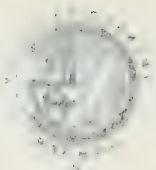
15 MR. RICE: Do you find many doctors
16 prescribe extensively their own drugs?

17 MR. ANTOfT: I think some in the country
18 but are remote from drugstores, and there are some
19 doctors that have special drugs who buy direct - ACTH,
20 for example, they may buy the drug.

21 THE CHAIRMAN: Have you any other
22 questions?

23 MR. WHITE: I have one or two. You
24 mentioned the average cost of a prescription in Denmark
25 was \$1 two years ago and in Canada it was \$2.78. Might
26 this be accounted for in part by the fact that Canadians
27 with somewhat a higher standard of living order more of
28 the drug each time it was required?

29 MR. ANTOfT: I think the standard of
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Antof

ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

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2 medical care and the type of drugs used are very
3 similar. I don't think that there is any significant
4 difference in the pattern of drug - type of drug used
5 or the quantity of them used. There may be somewhat
6 less over-use of some drugs in Denmark, but I wouldn't
7 like to say, answer your question.

8 MR. WHITE: And my last question, if
9 there is only one drugstore or pharmacy for 13,000
10 people, how are the small communities in rural areas
11 served?

12 MR. ANTOFT: They have drugstores - they
13 have drugstores, you must remember the population in
14 Denmark is compressed in an area that is not as large
15 as Nova Scotia so...

16 MR. WHITE: So there is no problem. It
17 strikes me that that is one reason why village drug-
18 stores and small general drugstores have to sell other
19 merchandise in order to operate in a small community.

20 MR. ANTOFT: Yes, I agree with that. I
21 am not saying that is a bad thing. I think these
22 drugstores that exist in the country, it is very neces-
23 sary they do exist and any way they have to adopt to
24 stay in business is for the community good.

25 THE CHAIRMAN: Anything further?

26 Gentlemen, I think we have all appreciated
27 the brief that Mr. Antoft presented to us. It certainly
28 explains things we have not previously received. I
29 do understand that Mr. Antoft came at some inconvenience
30 to himself, that he was on another trip and that he came



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2 to Toronto last night, and the fact that he voluntarily
3 asked to come before the Committee should be all the
4 more reason why we should gratefully appreciate the
5 fund of information he has given to us.

6 On behalf of the Committee, Mr. Antoft,
7 I want to express our appreciation, our sincere apprecia-
8 tion for the courtesy and for the information you have
9 given us.

10 Gentlemen, I believe our Chairman will
11 be back on Monday and we will again be meeting in
12 Committee Room 2 at 2.30 p.m. I think you all have
13 the agenda so I will declare the meeting adjourned
14 until Monday.

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16 --- Hearing adjourned at 12.45 p.m.
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